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In the Supreme Court

of the United States

OCTOBER TERM, 1951

No. 19

THE UNITED STATES OF AMERICA,
Appellant,

vs.

OREGON STATE MEDICAL SOCIETY, OREGON PHYSICIANS SERVICE, CLACKAMAS COUNTY MEDICAL SOCIETY, ET AL.,
Appellees.

Appeal from the United States District Court for the District of Oregon

APPELLEES' BRIEF

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APPELLEES' BRIEF

STATEMENT OF THE CASE

After reading the government's brief, largely devoted to the alleged evidence of a conspiracy against commercial hospital associations, the members of the Court will perhaps be surprised to learn that more Oregon doctors "take tickets" of commercial hospital associations than of the doctors' own prepaid medical care plan, Oregon Physicians Service (see infra, 70-3).

This must be one of the reasons why, even by accepting as true every opinion expressed by hospital association representatives as to the cause of the loss of certain accounts, the best that government counsel can assert is that as a result of *all* activities resulting from the alleged conspiracy "at least thirty verifiable accounts were lost by the hospital associations." Of these, "More than fifteen have been lost since 1945 and some of these . . . directly to O.P.S." (Br. 67-8). When it is considered that in the year 1948 Industrial Hospital Association alone had 508 contracts (Ex. 455, R. 7369) and that National had 840 (R. 7346), the puny nature of the "conspiracy" becomes apparent. And of course the possibility does exist that some of the explanations for causes of loss of accounts may have partly been influenced by sales representatives' attempts at self-justification.

The significance of the above facts is particularly emphasized when it is considered that Oregon, alone of all the states, has since 1917 permitted profit-making corporations to furnish medical care and that those doctors who have refused thus to "cooperate" with that type of medical practice have done so because of knowledge, gained by personal experience, of the vices inherent in any such system (see infra, 78-81 and Appendices B and C).

Another item of evidence that demonstrates the flimsy basis of the government's charge is this: It is actually a matter of indifference to the hospital associations, the presidents of the two largest of them testified, whether doctors take their tickets or not (see infra, 54-9).

The above, while perhaps the most important instances, are not by any means the only ones in which government counsel failed (perhaps because of only partial familiarity with the Record) to make good their assurance that if there were any evidence "tending to support the findings" they would not only so state but would "endeavor to summarize it fairly" (Br. 9-10).

Inasmuch as by far the greater portion of this brief will consist in a discussion of the evidence proving the fallacy of the government's contentions, we believe it would serve no good purpose to burden the Court in this introductory part with attempts to analyze each assertion in the opening portion of government's brief and expose the many fallacies contained therein.

We may say that the statement filed by us in opposition to the government's jurisdictional statement contains an eleven page summary of what we contend to be the facts of the case and the applicable law; and this brief is really an elaboration and documentation of that summary.

We do, however, at this point wish to call attention to some of the more glaring examples of counsel's failure to carry out their promise to set forth both sides fairly.

It is stated (pp. 65, 129)—apparently to make the point that one medical society "recognized the existence of the boycott"—that Jackson County Medical Society in 1940 passed a resolution that the boycott "be discontinued." But the statement is then made (129) that the "resolution was not carried out in practice." It seems to

us that candor surely would have required that reference be made to the ninety-four pages of the record setting forth government exhibits of extensive work for hospital associations by the leaders of the "boycott" in that county during the years immediately following the date of the above resolution (R. 6615-6, 6621 to 6715); and also to the letter signed by all, or practically all, the members of Jackson County Medical Society in September, 1941, insisting that all their names be included as cooperating doctors for the leading Industrial Hospital account in that region (Ex. 1854, 2702; R. 6733, 6986-7).

Another illustration is found in quoting from two letters from doctors (Br. 60-1, n. 64) to the effect that their refusal to take tickets or checks is due to medical society policy; and then failing to refer to the testimony of these same doctors explaining the letters and repudiating the inferences which counsel draw from them (Sears, R. 1982-83; Benson, R. 1701-8).

On the other hand, government counsel erroneously state that we had called but two witnesses (Br. 121, n. 3) to explain the hearsay evidence, in the form of letters, introduced by government counsel; and the government neglected to inform the Court that virtually all the writers of those letters were among the over 300 witnesses under subpoena by the government for several months, and were not called. It can fairly be assumed that after government attorneys and investigators contacted such persons they found that their stories would not hold up.

The theory of the government's case is that a conspiracy started on January 1, 1936; and so, pursuing this

theme, the government attempted to show not only that conditions got bad thereafter but that they were good theretofore. So, after detailing the alleged terrible conditions following 1936, the brief says (p. 52):

> "Prior to 1936, sales representatives of the hospital associations had found Oregon doctors friendly and cooperative (R. 532). With the development of this conspiracy, however, the situation changed. The 1936 policy statement of the Council of the State Society," etc.

Turning to the Record reference (R. 532), we do, indeed, find a representative of a large hospital association testifying that "at that time, why, physicians were friendly and they were cooperative," so much so in fact that "it was natural as I would go along with my other work I would call on a physician, and I would say, 'How do you do? How is everything going?' " The doctors "seemed to like it."

But what government counsel overlook is that this persuasive witness did not even commence to work for a hospital association until the year 1936 (R. 531). Continuing his testimony on cross-examination on the same page of the Record referred to by the government (R. 532) this representative testified:

> "Q. And this cooperaive and friendly attitude continued until when, about '41? A. It continued on, I would say, to probably around '38 or '39 or '40.
>
> Q. '42 is the first date, I think that you have given where you lost accounts. A. Well, around in that area.
>
> Q. 1940 you testified is the first date that any of

these troubles started to come. So up to about that time, anyway, it was much different than it is now, it was rather cooperative? A. Yes, there was a certain cooperation."

By 1940, the government's brief assures us, the "boycott" was "well under way" (Br. 118).

Lest it might be thought unfair to pick isolated statements in the brief for criticism, we shall set forth and then analyze the statements of approximately one full page of the brief, being really the high point of the government's principal contention.

After detailing at great length what counsel conceive to be evidence of a gigantic conspiracy to destroy commercial hospital associations, they summarize the effects of the "new policy" resulting therefrom as follows (pp. 53-4):

"Under the new policy, doctors, and sometimes hospitals, refused to 'take tickets'; i.e., they declined to look to the hospital association for payment of bills. Instead, the subscriber was treated as a private patient. Hence the patient, despite his coverage under the medical care plan, was required to pay the doctor for the services rendered. In some instances payment was delayed until the patient obtained the money from the association; in other instances he had to pay immediately and then obtain reimbursement from the association. This has led to disappointment, annoyance, and work for the patient (Gov. Exs. 11, R. 2121; 12, R. 2122; 1242, R. 4767; R. 668-70), and additional clerical and administrative details for the associations (R. 383-4, 538-40, 570-1, 808-9) and the employers (R. 717, 730-1, 848). Employees compelled to pay medical bills out of their pockets sometimes could not afford

> the unexpected cash outlays (Gov. Ex. 42, R. 2153; R. 894-5). This was particularly significant where hospitals refused to accept association tickets for their often substantial bills (Gov. Ex. 1335, R. 4931)."

We reserve for future comment (infra, 111-9) whether it is a crime for the medical profession to advocate collectively, a system of medical practice in which each doctor's patient is "treated as a private patient." We now address ourselves only to the accuracy of the statements in the above quotation.

Postponing for the moment the reference to hospitals, the first statement is that under this policy doctors "refused to 'take tickets.' " As above noted more doctors take tickets of these commercial organizations than of the doctors' own prepaid plan—more, as shall be shown, than ever before.

The statement is of course true that when the doctor refuses to take the ticket the patient is himself required to pay the doctor for the services, and it is also true that "in some instances payment [to the doctor] was delayed until the patient obtained the money from the association."

But government counsel are hard put to it to find evidence that any doctor ever insisted on cash, i.e., immediate payment, as the next statement alleges.

In fact, not one of the four references supports this latter statement. The first of them (Ex. 11, R. 2121) is merely a complaint of the "red tape" imposed by hospital associations which "I have to do" because the doc-

tor wouldn't. The second (Ex. 12, R. 2122) is a letter from a doctor returning a hospital check to the patient asking that he please return it to the association, obtain a check in his own favor "and then" pay the doctor. The third (Ex. 1242, R. 4767) is a letter from a lady employer to a hospital association complaining about the doctors not taking tickets, but not suggesting that the doctors insist on cash, in fact the only reference to he matter is that the doctor "finally charged it to him until it is payed by the Asso." The fourth and last (R. 668-70) is testimony of a lady that the doctor's nurse, or secretary, was somewhat dilatory in furnishing her an itemized statement. There was no contention that she had to make payment at the time of the treatment.

Incidentally, the last reference above involved an "individual" contract; and late in the case there appeared in evidence a letter from the largest of the hospital associations to the effect that on such a type of contract it was not desired that the doctor take the ticket at all, but should bill the patient (Ex. 2720, R. 7022, R. 1260-1, 1877; see infra, 57-8).

The above quotation from the government's brief has a further reference to employees' "unexpected cash outlays." The first citation (Ex. 42, R. 2153) is to a letter in which a lady stated that the doctor "refused to acknowledge" the association so she paid it herself "except for $18.00 that I could not meet at the time." There is no suggestion that the doctor insisted upon payment prior to reimbursement. (However, he might well have done so since it was for "Vitamin B intraveneous injec-

tions," and government counsel will have difficulty in finding any hospital association contract covering such type of treatment.) The next reference (R. 894-5) comes the nearest to evidence of payments by patients prior to obtaining payment from the association. That consisted of some hearsay testimony that "so the sawmill men like that don't have money to pay a doctor when they go up there" and similar conclusionary chatter.

The fact is that there is no evidence of a doctor ever requiring any such cash payments.

The next statement in the above quotation refers to "additional clerical and administrative details for the associations and the employers." Here our comment is of a different sort. It is true that there is less clerical work involved for an association, and perhaps for employers, when a doctor sends to the association a bill covering a month's services to various patients, than when the patients themselves individually take care of the "red tape" or the employer handles it for them. However, such additional work is hardly comparable to that which the doctors, or their assistants, must perform, without compensation, if they "cooperate" by taking tickets and proving to the associations that they are entitled to payment for medical services rendered (R. 1363-4, and infra 84-6).

The other statement that "sometimes hospitals refused to 'take tickets' " is elaborated upon by counsel later (Br. 72-3). We shall discuss it more hereinafter. At this point we merely summarize by stating that the four hospitals referred to on pp. 72-3 were small private

hospitals each operated by either one or two doctors in a small community and that the only general hospital that ever refused to take tickets, and that for but a limited time, is a small hospital in Eugene referred to on page 73. This refusal occurred in February, 1942 (Br. 73) and resulted in a proposed letter dictated (but possibly not mailed) by the president of the largest hospital association giving several reasons why "We prefer this plan where the employee personally takes up his bill" (Ex. 2728, R. 7029). There is no evidence that such refusal by the hospitals continued for any period of time.

As will be pointed out hereinafter (pp. 89-90), the large general hospitals in Portland did indeed on one occasion because of difficulties in collecting bills, resolve not to recognize "tickets," but to hold the patients personally responsible, leaving to them the handling of the "red tape" to secure reimbursement. But they shortly rescinded this action, after having given notice of it to but one prepaid care organization. And that one, to our chagrin, was the doctors' own Oregon Physicians Service.

Many places throughout the brief reference is made to articles appearing in the Oregon State section of *Northwest Medicine,* the inference being that these articles represent the official position of some medical society (see, e.g., Gov. Br. pp. 55, 56, 58, 77-9, 120). The fact is that the trustees of that publication made it very clear that it was "not responsible for opinions or statements made by authors in communications or papers" (R. 3905), that the "Opinions, Views or Comments presented in articles appearing in this section are those of the indi-

vidual authors and are not necessarily those of Oregon State Medical Society" (R. 3909). As we suggest hereinafter, the right of free speech is guaranteed to doctors as well as to others.

A doctor who was a member of the Board of Trustees of the above publication at the time articles quoted by government counsel were written testified that, to his knowledge, "the trustees have never exercised any control, any editorial control"; and:

> "The editors from various sections are primarily expressing their own views. Those views might possibly at the time express the point of view of the Medical Society in general or might express the views of a small segment of the Medical Society" (R. 1444).

He further stated that in his opinion the articles very often did not "express the views of the majority of the doctors." Continuing, the doctor testified:

> "A. Yes. I know that in two ways; first of all, that there have been articles that have appeared there that have not certainly expressed my point of view and articles that I did not consider—articles that I considered to be of questionable propriety under the circumstances under which they appeared. That is my own personal point of view.
>
> Q. Yes. A. And, on other occasions, members of the Oregon trustee group had received complaints from members of the Medical Society complaining about the type of articles that appeared in the Oregon section of Northwest Medicine" (R. 1445).

We now briefly summarize what we conceive to be the important facts, as follows:

Due to the intolerable condition created by the practices of commercial hospital associations, it is true that the Multnomah County Medical Society between 1936 and 1940 did expel certain doctors from the society by reason of their direct association with these unethical practices. No such expulsions, or disciplinary proceedings involving them, occurred subsequent to 1940 and none of them ever occurred in any other county of the state.

Beginning about 1941, hospital associations, because of demands of their members, and not because of medical society pressure, abandoned the "closed panel" system to a large extent and in the main permitted their members free choice of physicians. Thereafter, while it is not disputed that many doctors continued their violent opposition to these profit-making organizations—continuing to insist that patients cared for by them are "private patients"—they have been in the minority and, as noted above, in the course of time more doctors cooperated with these organizations than with the doctors' own organizations.

Furthermore, the proceedings by Multnomah County Society were only for the purpose of upholding the standards of the medical profession. They did not, as government counsel seem to contend, attempt to hinder or obstruct, much less persecute, doctors who cooperated in the unethical practices beyond compelling their removal from membership of the society. Nor was any doctor ever expelled or subjected to disciplinary proceedings merely for doing what government counsel state was

thereafter the desired "cooperation" with these associations—taking their tickets, i.e., billing the associations and accepting their checks.

As the government's brief seems to concede, there has not been a single instance in which any doctor was ever denied admission to any hospital staff, or any patient denied service in a hospital, or any doctor ever being unable to obtain consultation with other doctors, or any patient being denied service by any doctor, because of membership in or cooperation with any hospital association. Nor, the government's contentions to the contrary notwithstanding, since the year 1940 (and then only in Multnomah County) has there ever been any discrimination against doctors with respect to their medical societies because of their attitude toward or cooperation with hospital associations. Nor since that date has there been any attempt by any medical society to endeavor to prevent, even by suggestion, doctors from taking tickets of hospital associations. Many of them who do take such tickets—including, in fact, doctor-stockholders of one of the two leading hospital associations—have occupied prominent offices in their societies.

Elaboration upon all the above will be found in subsequent sections of this brief, as will also discussion of other contentions of the alleged sins of the doctors—such as opposition to fraternal medical plans, industrial contract practice, limiting competition among doctor-sponsored plans, etc.

SUMMARY OF ARGUMENT

As will be seen from the foregoing, the disagreement between government counsel and ourselves with respect to the alleged conspiracy against commercial hospital associations is largely on matters of fact, but not entirely so.

It is our contention that the actions of Multnomah County Medical Society in removing doctors from its membership for cooperation with improper practices was for the purpose of upholding the standards of the medical profession, and of confining the membership of the society to doctors willing to observe its code of ethics. Such objectives are legitimate and since no coercive or other illegal means were used—as in the *American Medical Society* case—there was no violation of the law, exclusion from the societies itself not being legal coercion.

Our second contention is that, regardless of the preceding views, since the practice of expelling doctors in Multnomah County was abandoned in 1940, has never been followed in any other county, and there is no threat of its resumption, what happened prior to that year is not material.

What has been done since then—the failure of some doctors to take tickets, etc.—has been the result neither of conspiracy, coercion or even concert of action. But even though it had been the result of concert of action or agreement, or of argument or persuasion, it is clear that such conduct would not be illegal.

In addition to their right to maintain and advance the standards of medical practice, we shall point out that the most that can be said of the situation in Oregon for many years past is that doctors have exercised their legitimate rights of free speech, of "legitimate persuasion and reasoned argument," and of protecting, by legitimate competition, the interests of themselves and of the public.

With respect to the charges of noncompetition between doctor-sponsored plans, the "allocation of territories" by doctors in selling their own services, and similar claims, to some extent the facts are as the government states, but the doctors in each such respect are acting clearly within their legal rights.

On the matter of interstate commerce, there is a wide variance between the claims of government counsel and ourselves. Here it is not, as so often is the case, a question of application of an agreed legal concept to disputed questions of fact, but largely a disagreement as to what the Sherman Anti-Trust Act really is. We disagree with government contentions that conduct was within the Sherman Act if it "involved and affected" interstate commerce (Br. 99) or was "within the Federal commerce power" (Br. 100). This is not our conception either of the inherent meaning of "restraint of trade or commerce among the several States," or of this court's construction of those words.

I. OREGON DOCTORS AND COMMERCIAL HOSPITAL ASSOCIATIONS

A. Period of Time 1936-1941

This case naturally divides itself into two periods of time. The first starts at the time when the alleged conspiracy is said to have started, in 1936, and ends about 1941. The principal events that marked the end of this period were (1) the organization of Oregon Physicians Service and the beginning of active competition throughout the entire state between the doctors' own prepaid medical care plans and the commercial hospital associations, (2) the last of the disciplinary proceedings in Multnomah County, which had resulted in expulsion from the society and resignations under threat of expulsion, because of cooperation with the then improper practices of hospital associations, and (3) the departure, in large part, by hospital associations from their closed panel system to the open panel system, giving in large part a free choice of physician.

We shall first discuss the events in the earlier period.

1. Situation confronting doctors prior to 1941—In general.

The intolerable condition which was being thrust upon the medical profession by the operations of commercial hospital associations and which reached its peak about 1936, is important in this case, for many reasons.

In the first place, the situation which the medical profession faced, particularly in Multnomah County,

makes it clear that medical societies then were acting solely for the purpose of upholding the standards of the medical profession, and in the public interest. This, under the authorities discussed later, they had the clear right to do, and this is all that they did.

In the second place, one of the reasons for the later change in the attitude of doctors toward hospital associations is obviously the change in the associations' method of operation and only when we know how they formerly operated can we know the extent of the change.

Finally, in determining the reasons why some doctors today do not "take tickets"—whether it is because of coercion, because of agreements, or simply the result of individual decisions based upon experience—the experience which doctors now practicing have had with hospital associations certainly cannot be ignored.

So a large part of the evidence on the part of appellees was devoted to the story of the vicious effects of the operation of commercial hospital associations, particularly prior to 1941. In those days in each community in which it operated the hospital association had a limited panel of doctors—in the smaller communities but one doctor. In Portland several doctors worked exclusively, or almost so, for these associations, on salary. The doctors in the outlying communities became little more than first aid men. Any serious case was required to be shipped to Portland. This saved money to the associations (R. 607, 1051). In fact, this practice extended to some extent to the more remote portions of the state, such as Medford, 300 miles distant (Ex. 2684, R. 6948). Doc-

tors—as the government's brief also points out (p. 22)—were required before giving any extensive course of treatment or performing any major operation first to get authority from the association. If authorization were given at all, it was sometimes only after a long delay—in one case from May 28 to July 13 (Ex. 1875; R. 6737-8). That the interference in the doctor-patient relationship, like the other abuses, was to increase profits, is shown by the fact that when the doctor was on a salary, even with limited experience and in a small community, there was no such interference (R. 1246-7).

The above practices of commercial hospital associations, particularly prior to 1941, are exemplified in extracts from letters sent by them to doctors, set forth in Appendix B. Extracts are also set forth from one of the hospital association's fee schedules showing the various types of medical and surgical services for which specific authorization was required prior to the rendering of service. In Appendix C we have set forth extracts from the testimony of numerous doctors respecting these practices of hospital associations and their demoralizing effects upon the practice of medicine.

Some of these associations were entirely owned by laymen, some by both doctors and laymen. The government's brief (p. 38) makes the point that in 1936 when the medical director of Industrial Hospital Association was facing disciplinary proceedings, that association took steps "to eliminate its single lay stockholder by purchasing his stock." That procedure, which in any event was an obvious subterfuge, does not change the basic objec-

tionable features of these commercial organizations. These features are, particularly, (1) that the profit motive dominates the relations of such an association with its subscribers and with doctors, and (2) the interference in the doctor-patient relationship is by the lay director. This interference was not merely formal or perfunctory. One of the doctors (who testified he was formerly "considered one of the fair-haired boys of hospital associations") gave the type of answers given him upon describing symptoms, by a layman 300 miles distant, as follows:

> "Well, if the patient's blood count is as high in the morning as it is this afternoon or this evening, why, you can go ahead and operate" (R. 1000; see also R. 1045-6).

Government counsel reminded the witness that these hospital associations had "as members of their regular staff licensed physicians" to which the witness answered that he "never at any time in all my association with them ever talked professionally to them [the doctors] concerning my patient"; and that in the conversation with the layman for permission to pursue a suggested course of treatment, the layman could not have talked to a doctor member of the staff for advice, because: "I think it was merely a quick decision on his part over the telephone, yes, that is correct" (R. 1022).

The same witness in answer to a question from the court stated that although over a period of twenty years he had handled several thousand cases for the State Industrial Accident Commission, he never once "had to call Salem or talk to any layman or any doctor in the State

Industrial Accident Commission office for permission to do anything."

The government brief points out (p. 161) that the regulations of Oregon Physicians Service require reports. However, while such power is reserved, it is seldom if ever exercised. Government counsel at the trial read portions of these regulations to a doctor cooperating physician of Oregon Physicians Service who had treated many patients of that organization (R. 1036-7). The doctor had never heard of any such requirement; and with respect to the "red tape" said "never to my knowledge have ever received a post card or anything such as you have just described" (R. 1037).

We are quite sure that there is not the slightest evidence in the record even suggesting that any layman associated with Oregon Physicians Service ever presumed to give or withhold authorization for a course of treatment, or even to intimate an opinion—other than perhaps whether the particular ailment was covered by the contract. For that matter, there is no evidence that the requirement of authorization is being enforced, even in the slightest.

This is not to deny that some sort of supervision—perhaps of "policing"—is necessary in a doctors' organization the same as in a commercial organization. But the big difference is this, that doctors naturally take much more kindly the supervision or suggestions from their own fellow practitioners, interested primarily in the welfare of the patient, than they do from laymen whose principal loyalty is to their profit-making corporate em-

ployers. In order that such supervision in Oregon Physicians Service might be from each cooperating physician's friends and neighbors, each county has a "supervising committee" of OPS. The friendly, cooperative point of view evidenced by members of these committees appears from minutes of those committees in evidence (See, e.g., Ex. 819 to 850, R. 4929-97).

The testimony of the conditions then existing did not come only from doctors. That grave abuse existed in the thirties was admitted by the Presidents of National—"we were not entirely without sin"—(R. 606) and of Industrial (R. 411-3). As pointed out at the trial (R. 643, 935-7), there were attempts to correct some of these abuses by legislative action.

However, it was not until 1941 that by legislative action employees were given some voice in the choice of doctors to be employed to render services under the hospital association contracts. Oregon Laws 1941, ch. 344, sec. 2. The same statute, sec. 6, outlawed the pernicious practice of payments and other favors to employers for "securing such contracts." These sections are now O.C. L.A., secs. 102-1402 and 102-1406, 1943 Pocket Supplement.

While it is clear that these so-called "hospital associations" are authorized by statute to furnish medical and hospital services, it certainly does not follow that the practices described above were legal. The statute (O.C. L.A., sec. 101-809) merely states that such corporations may contract or agree "for the furnishing of medicine, medical or surgical treatment, nursing, hospital service,"

etc. As pointed out hereinafter, even if nothing is done other than the furnishing of medical service by a profit-making corporation such action is considered the practice of medicine. But such a statute, which obviously should be strictly construed as inconsistent with the law respecting the practice of medicine, cannot be held to authorize more than the payment for the services rendered by the doctor. Specifically, it does not authorize dictation to such a doctor as to how he shall treat the patient.

For present purposes, the fact that these associations were violating the law probably is not of consequence. For doctors, like others, have the right to oppose established practices or customs, whether or not they are illegal.

2. Situation in Multnomah County 1936-1941.

In 1935 a committee of the Multnomah County Medical Society of which defendant Dr. Karl Martzloff was Chairman conducted an extensive investigation into the operations of hospital associations, including a prepaid medical care plan conducted by many of the members of that society and theretofore approved by it, Multnomah Industrial Health Association. This committee was known as the "Committee on the Study of Medical Care for Low Income Persons" and submitted a comprehensive report (Ex. 209; R. 2568). Because of the practices then indulged in by hospital associations, including Multnomah Industrial Health Association, the report disapproved these organizations. It recommended that the approval theretofore given Multnomah Industrial Health Association by Multnomah County Medical Society be

withdrawn. It also recommended that affiliation of members of the society with commercial hospital associations be disapproved, to the extent of expulsion from the society.

It should be noted, however, that the report pointed out that "an overwhelming majority" of the members of the society "favored some form of prepayment plan for the low wage earner" (R. 2576), a "large majority" expressing the belief "that the medical profession owes a moral obligation to the community to provide some plan for medical care of the 'low wage' earner (R. 2575).

As appellant's brief points out (pp. 28-9), to some extent the report of this committee divided members of the society into two groups, those opposing all forms of then existing hospital associations, including Multnomah Industrial Health Association, and those wishing to perpetuate that organization.

During the four years following that report—whether as a result of it or not is not known—hearings were had, conducted by a disciplinary committee before the Board of Censors of the Multnomah Society. As a result of these hearings several doctors were expelled from that society and others resigned from the society rather than face expulsion. Others after conference with the Board of Censors discontinued working for hospital associations.

In connection with these proceedings, we believe it is necessary only to point out four facts, as follows:

1. No member of Multnomah County Medical Society was ever expelled from that society or threatened

with expulsion merely because he rendered services to patients covered by hospital association contracts or because he took tickets of any hospital association, or rendered his bills for services to hospital associations, or accepted checks from hospital associations (R. 1434). The proceedings were against those on the limited panels of these hospital associations, mostly upon salaries, doctors involved in solicitation or advertising, and in effect engaged in fee splitting with lay organizations. It was these objectonable practices and not merely "contract practice" that violated ethical principles.

2. The above proceedings were in no sense punitive in nature. The officials of the medical society were convinced that what was being done was in violation of the society's code of ethics. It was a course of conduct which, as courts have said, inevitably degrades and debases the medical profession and the enforcement of that code of ethics, as experience had shown, was manifestly in the public interest. When doctors were admitted to membership they agreed to be bound by that code of ethics.

For present purposes, it is immaterial whether one does or does not believe in such a code. It is sufficient that this organization did believe in it. One of its purposes was to promote that code. Those who did not believe in the objectives of that code were simply associated with a group where they did not belong. Therefore they should get out; and the procedure was without ill will, without rancor, and for the most part without effect on an otherwise friendly relationship.

3. For the above reason, no further action was taken

by the society against the doctors who were expelled or who resigned, other than the expulsion or the acceptance of a resignation. The proceedings were in no sense intended to be coercive. As the Chairman of the Grievance Committee in 1936, defendant Martzloff, testified (R. 1438):

> "First of all, we didn't want to do anything to in any way injure an individual just because he happened to be involved in unethical practices in violation of the constitution and by-laws. We insisted that if a man wanted to be in violation of the constitution and by-laws he should either correct his conduct or drop out; but if he did not want to drop out voluntarily, then he should be expelled. We would much prefer to have an individual give up his violation of the constitution and by-laws; we would much prefer to have him do that than to have to proceed in a disciplinary manner."

Accordingly, a recommendation in the above mentioned committee report that an effort be made to keep doctors off hospital staffs who were not members of the medical society was not carried out (R. 1433). We particularly desire to emphasize this point, since although the government brief points out that the Martzloff report recommended that membership in a society be a requisite to staff membership in a hospital (Br. 70) it neglects to point out that that recommendation was never followed.

In fact, the evidence is conclusive that no doctor has been kept off any staff of any hospital in Multnomah County, nor for that matter in the State of Oregon, because of any connection he may have had with any com-

mercial hospital association. Indeed, the medical director and large stockholder of National Hospital Association, Dr. Sabin, not only continued as one of the valued and honored members of the staff of St. Vincents, but upon his death the doctors upon the staff of that hospital joined in the collection of a fund for a memorial to his memory (Ex. 2736; R. 7039; R. 680).

The complaint in the present case, it is true, charged that such expelled doctors were kept off the staffs of, and not permitted to practice in, hospitals (R. 8, 9). Though directed to do so by the court, the government has been unable to furnish the name of even one such doctor or hospital (R. 54, 67-8, 73, 75-82). The fact is that no doctor has ever suffered any financial loss by reason of not belonging to a medical society (other than a slight increase in malpractice insurance premiums), nor has any doctor ever been kept from the staff of a hospital nor any patient ever refused hospital service in Oregon either because of nonmembership in a society or because of cooperation with or membership in a hospital association. We do not understand that the government claims otherwise, except as is pointed out (p. 71) Vanport Hospital when operated by OPS limited staff privileges to OPS doctors. That hospital, as one of the government's witnesses testified (R. 744-5), was taken over by OPS (or the medical society, the witness was not certain) from the government for the purpose of taking care of shipyard workers, then subscribers to OPS. So there was no occasion for others than OPS physicians to use the facilities of that hospital until later when Permanente

took it over, at which time the Permanente doctors operated it.

The only other evidence on this subject to which the government refers, other than the 1936 recommendation above mentioned, is a letter, to which no reference was made at the trial, apparently written by Dr. Shea to Dr. Fitzgibbon recommending that Dr. Suckow be admitted to staff membership in one of the hospitals. Dr. Shea's letter refers to the fact that Suckow theretofore had done hospital association work, but that "he repudiated this type of practice." Fitzgibbon's notation that Suckow should be admitted to membership makes no reference to Suckow's former hospital association activities. It is accordingly extremely doubtful whether this letter is even hearsay evidence that these former activities influenced either Dr. Shea or Dr. Fitzgibbon unfavorably in the least. As far as Dr. Fitzgibbon is concerned, he was a witness thoroughly examined and cross-examined (R. 1334-59) and the government presumably can find nothing in his testimony suggesting that in 1946 he entertained any unfriendly feelings toward Dr. Suckow.

The government's brief endeavors to emphasize, if not exaggerate, the importance of membership in medical societies (Br. 23-5, 115-7). The language of the brief is couched in general terms comparing medical societies with comparable organizations in other fields. But we are here concerned with Oregon medical societies and the extent of their importance to doctors in that state. The fact that in 1936 only 61% of the doctors of Oregon, 742 out of 1215 (R. 2029), maintained membership in the

State Society does not indicate that either from a financial or social standpoint such membership was regarded as indispensable to success. The evidence also shows that in the three years immediately preceding filing this suit an average of almost 30% of the licensed doctors of the state did not belong to Oregon State Medical Society (R. 111). More than 400 Oregon doctors thus did not feel the great compulsion which the government thus relies upon.

In short, the policies of the Multnomah Society—resulting in the ousting of some of its members in the '30's —were intended to govern the conduct only of members of the society. There was no attempt to force those policies upon nonmembers, even though they might be former members.

The same was true of the State Society. Exhibit 2726 (R. 7028) is a letter dated January 16, 1940, from Oregon State Medical Society to a doctor who had inquired regarding the policy of the society on certain matters concerning commercial hospital associations. The letter courteously explained that the society had a policy. It pointed out, however, that the policy "was adopted for the guidance of members of the Oregon State Medical Society," and concluded by stating that the records indicated that the inquirer was not a member of that society.

That the procedure adopted by the Multnomah Society was purely for the purpose of maintaining its ethical concepts and the standard of conduct of the profession, and was not actuated by malice or ill will nor destructive in nature, it seems to us is further conclusively shown

by the society's action with respect to Multnomah Industrial Health Association.

The organization of that prepaid medical care organization was under the sponsorship of Multnomah County Medical Society, but in 1935 after the issuance of the Martzloff report the Multnomah Society withdrew its approval of the organization. Certainly if, as the government contends, the object of the Multnomah Society, or of the State Society, had been to destroy commercial hospital associations, rather than to maintain the society's ethical standards, the Multnomah Society would not have withdrawn its approval from the above organization.

4. In 1940 these disciplinary proceedings stopped. They stopped much more abruptly than they had started. They were never resumed.

The suddenness with which these proceedings terminated is well illustrated in the case of Dr. C. H. Palmer. The transcript of proceedings before the Board of Censors in June, 1940, discloses that toward the end of the proceedings the chairman made this statement to Dr. Palmer:

> "The majority of the medical profession are united in considering these lay-owned and lay-operated hospital associations as unethical. They restrict the rights of physicians, they limit the number of men that patients can go to, they don't have free choice of physicians, and many other things, so we have only one thing that we can do, Doctor, and that is to ask you to discontinue working for these unethical hospital associations" (Ex. 1057; R. 4434, 4446).

Dr. Palmer did not discontinue working for the hospital associations. Neither was he expelled. Nor did he resign from the society (R. 686-7). Almost ten years later, at the trial of the present suit, and while still a member of the society, he steadfastly continued to defend his position (R. 681-6).

The reasons for this abrupt termination of these proceedings will be discussed later, infra 46-54.

3. Presidents and members of Council of Oregon State Medical Society 1936-1941.

The government's brief strongly argues that at the time the Multnomah County Society was conducting its disciplinary proceedings, the State Society was conducting a vigorous campaign statewide for the eradication of commercial hospital associations. As we suggest in the next subdivision of this brief, perhaps one needs to have had more experience with voluntary associations of this type, and what goes on at their meetings, than government counsel may have had in order to place the reports, resolutions and minutes in their proper perspective. The fact is that while there was some talk elsewhere in the state at society meetings, usually not well attended, no disciplinary proceedings were ever conducted elsewhere than in Multnomah County. And when we consider the individuals who were leaders of the State Society during the period in question we are forced to drastically discount the paper record referred to in the government brief.

On January 1, 1936, when the complaint alleges this conspiracy started, Oregon State Medical Society had

742 members, being 61.1 per cent of the licensed physicians of the state. This percentage of membership was not exceeded until 1940. The President of the Society was Dr. G. O. Massey of Klamath Falls. There seems to be no evidence in the record of his attitude toward hospital associations, unless the By-Laws of Klamath Medical Service Bureau, adopted December, 1939, is evidence of that attitude. Those by-laws, which will be referred to hereinafter, provide (R. 4668) that the doctors of Klamath Falls may work for such hospital associations provided that open panels are maintained.

At the date of the commencement of this so-called conspiracy Thomas W. Watts was president-elect of OSMS and was elected President at the next election in the fall of 1936. One of appellant's principal witnesses, C. C. Bechtold, testified (R. 598):

> "Q. Now, Tom Watts was once President of the Society. Did he cooperate with the association?
> A. Yes, Tom Watts was very cooperative.
> Q. Very cooperative?
> A. Yes."

Defendant Fitzgibbon who himself was not an enthusiast for commercial hospital associations, was told by Dr. Watts that he accepted tickets both from the National and from the Industrial Hospital Associations (R. 1348).

So we have a situation where the first president elected after this conspiracy was said to have been organized was a friend of both National and Industrial Hospital Associations. And at that same election in the fall of

1936 there was elected as president-elect of the State Association Dr. Charles T. Sweeney of Medford. Concededly he was not only friendly to but an enthusiastic supporter of National Hospital Association (see Ex. 24, 1346, 1557, 1752; R. 2133, 4943, 5187, 5348). His own testimony by deposition, is in evidence (Ex. 1859; R. 289-300).

In this deposition Dr. Sweeney admitted his warm friendship toward and cooperation with the commercial hospital associations, explained that the doctors of the state knew his attutde when they elected him, and emphatically denied that there was anything in the nature of a conspiracy at that time (R. 297).

He was convinced, so he testified, that the source of Multnomah County's controversy over hospital associations could be traced to a speech by Dr. Morris Fishbein made at a meeting of the Multnomah Society in 1936. He charged, as the government's brief points out (p. 32, n. 35) that Dr. Fishbein "came out here and stirred up more trouble than any man who ever came into the State of Oregon" (Ex. 1859, R. 298).

Such was the extent of Dr. Sweeney's work for and support of hospital associations that two of the physicians of his local society, Jackson County, endeavored to have that county discipline him, but without success (Ex. 1752, R. 5348; R. 292-6).

So at least for two years beginning in the fall of 1936 we have the presidency occupied by doctors friendly to commercial hospital associations.

Members of the State Council were likewise friendly to them. Some of these members, including some presidents of the State Society, were outspoken in their opposition to the disciplinary proceedings then taking place in the Multnomah Society (Moore, R. 396-7). To such an extent was this the case that it embarrassed the members of the Grievance Committee of the Multnomah Society in those proceedings. In an endeavor to remedy this situation, that Committee requested the Council of the Multnomah Society to transmit a protest (Ex. 2682, R. 6934) to the Council of the State Society (Ex. 2754; R. 7058); and that protest was presented to the State Council but no action was taken on it (Ex. 2755; R. 7060, 7061). The resolution in which this protest was embodied contained the following language:

> "Whereas, the Grievance Committee has lately been handicapped and hampered in carrying out their duties by statements of members of the Multnomah County Medical Society that certain officers and members of the Council of the Oregon State Medical Society are engaged in similar unethical practices;" (R. 7060).

One of the members of the State Council during this period prior to 1941 was Dr. Thompson Coberth of The Dalles, later President of the association. In a letter to Dr. Moore (Ex. 1852), September 4, 1939, he said:

> "I assure you I have never been in favor of the action on the part of the Multnomah County Med. Soc. regarding you fellows. In fact have said so in the State Committee meetings and have been promptly told it was none of my business as I do not belong to that society. However I do not feel

that way. I did not consider it fair play and feel that it affected the profession of the Entire State" (R. 5499).

Then about a year later when defendant Hunt was President of the Society he invited Mr. Bechtold, President of National, to attend the Council meeting and explain his company's contracts. Mr. Bechtold testified (R. 597-8) that he was "very courteously received * * * flabbergasted at my reception" and the members of the Council complimented him on what he said.

Bechtold said (R. 597) that "situations like this [i.e., this suit] could have been avoided" if others had "entertained the same views" as Dr. Hunt.

Contrast the above characterization of Dr. Hunt with that in the government brief, where is placed at the forefront of the conspiracy (R. 35, 37, 74 and Appendix A). This doctor, by the way, though president of the State Society in 1940 and one of the defendants in this suit, was one of the doctors named by the government as having been "subjected to specific coercion, compulsion, harassment, threats or pressure" and thus being "deprived of an opportunity to practice medicine in Oregon on terms of their own choosing" (R. 63-4). As the government points out in the appendix, he is a specialist in obstetrics and gynecology, not covered by hospital association contracts until 1947.

With this complexion of the officers and the members of the Council of the State Society it can hardly be said that the State Council was in a conspiracy with

Multnomah County Medical Society, nor that the other County Societies were a part of any such conspiracy.

4. Events in state, other than Multnomah County, 1936-1941.

(a) *In general.*

It is a good guess that government counsel have never regularly followed the meetings of some professional organization such as a medical society, or a bar association. To get a proper perspective they might well have attended some bar association convention, and, among other things, inquired among the members as to what items of business were being considered and what resolutions had been passed. They would perhaps have been shocked at how uninformed many members would have been upon subjects which counsel would have thought of importance.

Counsel have given the minutes of these societies careful study. Any of them today is better advised as to the procedings of any given meeting than the members present were immediately upon adjournment. To place the matters of "contract practice" discussed at these meetings in their proper perspective one should consider the great number and vareity of other topics.

To get this perspective one should also consider the following:

By 1939, according to appellant's counsel, the conspiracy was well under way, the State Council had the doctors of the State well under control, a united front had been established against commercial hospital associations.

Clatsop County was well represented at the forefront of this conspiracy (Br. 66).

But in May, 1939, Clatsop County Medical Society unanimously passed a resolution that thereafter they would "render service only to individuals under coverage of the National Hospital Association and the Industrial Hospital Association" and not to Multnomah Industrial Health Association, recently approved as a doctor-sponsored organization (Ex. 911, 913; R. 4293, 4295).

In November of this same year of 1939, while Dr. Coberth (referred to above) was a member of the State Council, the Secretary of Mid-Columbia Medical Society, which included Dr. Coberth's County of Wasco, wrote a letter to all hospital associations and to OSMS. This letter (Ex. 1233; R. 4756; Ex. 2000; R. 6102) stated that the doctors of that district *"in cooperation with the Council for the Oregon Medical Society"* had considered the problems of prepaid medical care. After such cooperation with the State Society, the local society decided:

> "that we should invite all or any of the organizations handling this type of contract to do business in our community,"

subject only to an income limitation on full coverage individual contracts. Copies of this letter were sent to National and Prudential Hospital Associations as well as to Multnomah Medical Service Bureau.

Dr. Massey of Klamath county was the President of Oregon State Medical Society when this conspiracy is said to have had its inception. Yet after this conspiracy

had been in operation for four full years, that is in December, 1939, upon the organizatoin of Klamath Medical Service Bureau (a doctors' organization), the only limitation it placed upon its members in working for commercial hospital associations, as we have already pointed out, was "that such hospital association shall likewise list as physicians to such association, every other member of this Bureau" (Ex. 1152; R. 4668, 1402).

Do government counsel contend that the sole object of this conspiracy was to require an open panel?

One of the defendants is Dr. Joseph P. Brennan of Umatilla County. At the very inception in 1936 he was a member of the Council of OSMS; and during the years 1936-37 was a member of the House of Delegates of the State Society. Accordingly, if there was a conspiracy to destroy commercial hospital associations Dr. Brennan knew about it. But in February, 1940, neither Dr. Brennan, nor apparently other members of the Umatilla Society, knew whether the State Medical Society had *approved* the National Hospital Association! So this defendant wrote to the State Society to learn about it (Ex. 2037; R. 6323).

Notwithstanding this ignorance of the objective of a conspiracy of which he was supposed to be a part, Dr. Brennan was elected one of the original trustees and directors of OPS and has continued in both positions ever since. Meanwhile, he himself continued taking tickets of commercial hospital associations until "five or six years ago" (R. 1601-2), i.e., prior to the trial. He quit, not because of a conspiracy, but because these hospital

associations "questioned your procedure to the point where it was insulting * * * and I just got fed up with it" (R. 1602).

Incidents such as the above, in such widely scattered points as Clatsop, Wasco, Umatilla and Klamath Counties, place the minutes—with their resolutions and proposals and "Dr. Jones said this" and "Dr. Smith made this proposal"—in their proper perspective. Compare Mr. Justice Douglas's statement in *United States v. National Association of Real Estate Boards*, 399 U.S. 485, 494-5, approving the trial judge's action in giving to the realtor's code of ethics only such weight as he thought the circumstances warranted.

(b) *Events in counties other than Multnomah, 1936-1941*

As already indicated, the contradictory and inconsistent positions taken in the various counties during the period 1936 to 1941 utterly refute any contention that events were being shaped by a group of conspirators; or for that matter that there was anything in the nature of a state-wide movement.

That there was an entire lack of concert or uniformity of action in the several counties further appears from Appendix B where we have set forth a chronological list of events in counties other than Multnomah during 1936 to 1941.

We mentioned above the prepaid medical care organization of doctors in Multnomah County in the early thirties, Multnomah Industrial Health Association. In

other counties also doctors had organized for the same purpose.

About 1930 the doctors in Salem, Marion County, for the purpose of providing their services on a prepaid basis, organized the Physicians and Surgeons Hospital Association (R. 1282-7). Most of the doctors of the county joining that organization in the course of time ceased working for hospital associations (R. 1287). But since in those days the commercial associations had but limited panels anyway, this apparently did not bother them.

Likewise, shortly thereafter the doctors of Jackson County organized the Southern Oregon Medical Service Association (R. 999). However, here too the hospital associations were maintaining only limited panels and the doctors' organization did not give them very keen competition (R. 1006-8). In fact, we find during the three years ending in 1935 that several Medford doctors endeavored to get on the panel of National Hospital Association, but without success (Ex. 2131 to 2135; R. 6498-6502).

(5) Motives of Defendants.

(a) *Ethical considerations.*

In our discussion of the activities of the Multnomah Society in the thirties in removing doctors from the society, we explained in some detail that the motive of the members of that society was to maintain and advance the standards of medical practice and regulate fair dealings among the members of the society (supra, 24-8).

That they were within their legal rights in attempting to attain those objectives by the means employed is shown later (infra, 107-11).

In discussing the charges made by the government that both in the organization and in the conduct of Oregon Physicians Service and other doctor-sponsored plans the purpose of the doctors has been improper, we shall point out that the doctors have been motivated by a desire to carry out the highest traditions of the medical profession in providing the best of medical care to all groups in accordance with their ability to pay, and particularly to provide it to the low income groups at low cost (infra, 96-7).

We take the liberty of suggesting to the court that a sound mode of approach in determining what the motives actually were is that recently adopted by the Supreme Court of Washington. *Group Health Cooperative of Puget Sound v. King County Medical Society*, 139 Wash. Adv. Sh. 541, November 15, 1951. Doctors there claimed that their motive in opposing Group Health Cooperative, a non-profit corporation, was to uphold the ethical standards of the medical profession and the claim was made that Group Health and its doctors were engaging in unethical and improper practices. Among these, defendants contended were the following:

> "unreality of consent of contractees; extravagant promises by salesmen; bribery to secure contracts; lack of scientific meetings; profit to third party; lack of personal touch between physician and patient; solicitation; tendency to make money out of con-

tracts; underbidding to secure contracts; and control by lay operators" (139 Wash. Adv. Sh. at 564).

The Court carefully reviewed the evidence claimed to sustain each of these contentions and found all of them to be without merit.

Therefore, the Court concluded, "the Society's primary motive in opposing the cooperative and its staff members is to restrain the competition which the cooperative provides through its industrial contracts" (*ibid*).

If exactly the same mode of approach is adopted by this Court, exactly the opposite result will be reached from that in the Washington case. The Washington court found the situation to be precisely the same as that involved in the *American Medical Association* case.

Adopting the same criteria as the Supreme Court of Washington, we find the facts in Oregon to have been as follows:

(1) "unreality of consent of contractees." As pointed out, prior to 1941 the employees had no voice whatever in choosing hospital associations, and thereafter but very little (Or. L. 1941, ch. 344). (2) "extravagant promises by salesmen." (Dr. Moore, "You went to work and contracted to deliver strawberries on the top of Mt. Hood" (R. 411). (3) "bribery to secure contracts." (Dr. Durno, "suites of rooms, whiskey and flowers" R. 1228). (4) "lack of scientific meetings." (No pretense that hospital associations have them.) (5) "profit to third party." (Only purpose of existence of commercial associations.) (6) "lack of personal touch between physician

and patient." (See supra, 17-8, 79, on closed panels, and 78-9 on local doctors being only first aid men.) (7) "solicitation." (Not only existed, but without consent of doctors whose services were being sold.) (8) "tendency to make money out of contracts." (As the government's brief intimates, p. 161, this was the reason for interference in doctor-patient relationship.) (9) "underbidding to secure contracts." (Perhaps this is permissible competition.) (10) "control by lay operators." (True here, to the extent of telling doctors when and how to operate, supra, 18-9; and see Appendices B and C).

The facts being just the opposite of those in the Washington case, an opposite conclusion is demanded.

In addition, the Washington Supreme Court found that unlike the Multnomah County Society the defendant doctors did not stop with the exclusion of doctors from their societies. They also prevented them from access to the hospitals, and from consultation with Medical Society members.

(b) *Economic aspects of doctor's position.*

The government's brief points out "the economic threat of the commercial associations to the doctors' fee practice" (p. 159) and charges that their "unrelenting opposition" (p. 109) was due to economic and not ethical considerations.

One of government counsel was taken aback at the trial by a doctor's answer when he goaded the doctor with the fact that under the operations of Southern Ore-

gon Medical Association in the early thirties the doctors found that, because the commercial associations had already cornered all the valuable contracts, their association paid them only twenty to thirty per cent of their fee schedule. "And you think that was comparable," government counsel queried, "with what these doctors had received from commercial associations?" (R. 1022). "It was not," answered the doctor, "but we had freedom which we didn't have" (under the former system) "and that was the extra compensation."

> "Q. But the extra compensation did not consist of extra remuneration? A. Not in terms of dollars and cents. You can't measure the practice of medicine entirely in terms of dollars and cents."

That is not to say, however, that the economic aspect did not play its part. Starvation wages have always been productive of discontent, and we suppose doctors are not immune to such influences. The motive of improving one's economic status is not condemned by law (see infra, 120-2). Accordingly—and without agreeing that economic and not ethical considerations have been paramount—we point out some of the economic effects upon doctors of practices of these commercial associations as they operated in the '30's.

Since their business was confined, practically exclusively, to employed groups, their "members" (as they like to call them) consisted of persons, judged by the standards of depression days, of the higher economic group, those able to pay their way. To the private practice was left the nonpaying charity group.

But the doctors on the associations' limited panels hardly can be said to have accumulated wealth by their service to the associations. In fact, it seems to have been a case of letting out the work to the low bidder.

Thus, in 1935 one of the associations promised $2.00 for the first office or hospital visit, with subsequent visits at $1.00 each. Residence visits were $2.00 (Ex. 2686, R. 6953). Mileage was 50¢ per mile. This actually meant that if a doctor drove five miles beyond the city limits and back, caring for a patient at the destination, his total pay, including use of car, was $3.50.

For a time the associations were able to persuade the State Industrial Accident Commission to permit them to furnish the doctors for services under the State Workmen's Compensation Law. The pay to doctors for such services was not the modest fees allowed when doctors worked directly for the Commision, but those fees *less one-third* (Ex. 2686, R. 6953). (Nevertheless, a recommendation of the State Society that the State Industrial Accident Commission should not let such contracts to hospital associations is cited by the government as evidence of this conspiracy (Br. 58-9); as apparently also is the opinion of a local society that when the associations have such contracts they should pay the same fees as the State Commission (Ex. 1234, R. 4757-8, referred to in government's Br., p. 59, n. 62).)

In those days the associations, except for the house and office visits, furnished no fee schedules to doctors (R. 1003, 1190), and so doctors never knew what to expect when other than simple cases were treated.

But uniformly the doctors' bills were discounted. (See, e.g., R. 6774-82.) Sometimes this was done with the notation "per schedule"; sometimes the explanation was that too large a proportion of the doctors' cases had been given a certain type of treatment or examination (Ex. 1935, R. 6749); sometimes it was because the services in a given case were more extensive than the doctor had estimated or than were "authorized or contemplated" (Ex. 2577, R. 6808-10); very often it was just a case where the association would "send a long cock-and-bull story about they didn't allow so many treatments for that kind of case" (R. 1595). And even as late as October, 1949, payment was refused because "the service was rendered . . . without authority from this Association to provide the service at its expense" (Ex. 2708, R. 6994).

So, if there is truth in counsel's statement (Br. 156) that "ethical standards wear the dollar sign," the above is the reason.

B. Period of Time Subsequent to 1941

1. Change in situation, 1940-2.

As pointed out above, in no county other than Multnomah has any doctor ever been expelled from a medical society or threatened with expulsion by any medical society by reason of any conduct with relation to commercial hospital associations. And in Multnomah County no doctor has been expelled or threatened with expulsion for any conduct with relation to commercial hospital associations since the year 1940.

Furthermore, one reading the minutes of the various medical societies cannot help but be struck by the fact that while there was considerable discussion prior to 1941 indicating antagonism to, and plans for combating, practices of commercial hospital associations, such discussion seems almost entirely to have ceased about 1941. True, there has been general discussion in Multnomah County, and in the State Society, with respect to railroad doctors, telephone employees' medical service, and similar types of "contract practice." But even in these instances what was done was nothing more than discussion; it did not even extend to persuasion or argument.

The reasons for this marked change is perhaps not of importance—the important thing is that the change took place. The following might, however, be pointed out as contributing factors to this change in attitude on the part of the doctors.

(a) *American Medical case.*

The decision on the first appeal in the *American Medical Association* case, 110 Fed. (2d) 703, was given March 4, 1940. There is evidence that this decision had a sobering influence on the doctors (R. 1439; see also Ex. 530; R. 3590, 3593). While, as we shall point out, we are convinced that that decision does not condemn but clearly approves the type of proceedings had in Multnomah County or in the rest of the State under the facts then existing, the study we have made of that decision had not been pursued by the average doctor.

(b) *"Worst offenders" out.*

It has been suggested that the "worst offenders" against the principles of medical ethics in Multnomah County had been expelled, or had resigned, from the society (R. 1439). There was, as has been testified, no desire that any doctor should be expelled for doing what most doctors are today doing, and what the associations say is all they wish doctors to do, that is, merely taking tickets of hospital associations, sending them bills, or accepting their checks (R. 1434).

(c) *Competition by medical societies.*

Since 1941, the medical societies in Oregon have been in competition with commercial hospital associations. As Exhibit 208 (R. 2563), pointed out, Multnomah Society in 1936 was "definitely divided" into two groups, those opposed to all forms of contract practice, and those who believed that the doctors themselves should offer a plan of prepaid medical care. In 1941 the latter alternative was adopted by the State Society. By presenting to the public, including those holding contracts with the commercial hospital associations, a plan whereby members would have a wide choice of physicians and under which there would be no intereference with the doctor-patient relationship, the doctors hoped to set up a standard of prepaid medical care contracts which would be attractive to the public and which competitors, for competitive reasons, would be required to adopt. At any rate, members of the public who desired this better type of service could procure it.

Of course this was not entirely new. Theretofore, as already explained, there had been several doctor-sponsored plans in the State—in Marion, Clackamas, Lane, Jackson, Coos and Klamath Counties. In addition, there was the Multnomah Industrial Health Association in Multnomah County, later known as the Multnomah Medical Service Bureau. These organizations themselves had been motivated by a similar purpose.

The first of these was the Physicians and Surgeons Hospital Association in Salem, and defendant Baum who was one of the organizers explained its purpose as follows (R. 1286):

> "We wanted to set up a type of prepaid medical service which would be on a higher level, higher ethical and professional and moral standard than had been before, and at least some of us—I know I for one, and I know others who have discussed it with me for long hours were sincerely and honestly interested, and still are, even more so to this day, interested and desirous of helping the average individual to have some method by which he might avoid the impact of a very serious illness;"

Defendant Besson described his attitude toward Multnomah Medical Service Bureau and his activities in connection with it, as follows (R. 1508):

> "I felt that my allegiance was to the Medical Society organization, which was established for the purpose of furnishing better prepaid medicine to the people, and I felt we had a better type of goods to offer to the people and I was promoting it and pushing it and trying to get business, let us say, from the competitor and to get business before the competitor got it, by giving better service. If that is

something in restraint of trade, that is as far as it went in my activity."

It is unnecessary for us here to discuss in detail the various factors which, by various groups of doctors, were considered important in the organization of OPS. On this see particularly Dr. Baum's testimony (R. 1291-5). Generally speaking, the purposes of the organization were two-fold: First, to arrange for the coordination of the activities of the various doctor-sponsored organizations then existing, particularly for the care of patients of those organizations when away from their respective localities; and, second, for the sale of prepaid medical care to statewide organizations and to organizations in those counties where it was not then being sold by doctor-sponsored organizations (see R. 1291-5, 1440-1, 1654). Its purpose was to supplement, not to supplant, other doctor-sponsored plans.

(d) *Adoption of open panel and indemnity principle by hospital associations.*

We regard this as perhaps the most important reason of all. Starting about 1940, the commercial hospital associations changed from the service type of contract to the indemnity type of contract (Bechtold, R. 1756-7). OSMS had made it clear that Oregon doctors favored the indemnity type of contract (Ex. 712; R. 3897).

The hospital association officials tell us that their shift from their earlier form of contract, whereby they furnished services through a limited number of doctors, to the indemnity type of contract was because they real-

ized that the public demanded it and that it was in the public interest, and not because of any medical society pressure (Moore, R. 379-80; Bechtold, R. 606-7, 1756-7). It was, everybody seems to agree, a change in the right direction. To the extent that the hospital associations have practiced what they preach—that is, maintained the indemnity principle with the consequent free choice of physician—they have eliminated the most objectionable features of the old system.

As pointed out in the government brief (p. 21), even prior to 1940 some of the hospital associations to some extent had been abandoning the closed panel. This was done in the smaller communities where all the doctors insisted upon it. It is not true, however, as the brief suggests, that by 1940 it had been entirely abolished. Even now, some of the present contracts of National Hospital Association (see, e.g., Ex. 72, R. 2181) provide for services only by physicians designated by the association, and as Mr. Bechtold, president of National, testified, "we reserve the right to designate the doctors, although it has not been done for a number of years" (R. 638).

We shall point out later that there are still abuses, but as the evidence so clearly proves the situation is much different than it was in the thirties, and the difference is for the better. The difference is not only in the service given by the commercial associations, but also in the greatly increased number of doctors who take their tickets. Several doctors testified to this change, particularly those who had been away from the state in the service. The following testimony of Dr. Underwood is typical (R. 1457):

> "Following the return from the army, I found the situation entirely different, and at that time I found that generally patients were being seen by most of the physicians as far as I could tell, around Portland, and at this time the organization did not have a closed panel and had changed to some extent, in that it was an insurance type of coverage."

(e) *The waning of the Fishbein influence.*

As mentioned above, and as the government's brief points out (p. 32, n. 35), in the spring of 1936 Dr. Morris Fishbein of the American Medical Association made a speech in Portland; and Dr. Sweeney, shortly thereafter president of the State Medical Society, attributed to that speech the subsequent conflict in medical societies over hospital associations. Dr. Fishbein, according to Dr. Sweeney, "came out here and stirred up more trouble than any man who ever came into the State of Oregon" (Ex. 1859, R. 298). Dr. Sweeney further testified as follows:

> "If Morris Fishbein had not been out here, they wouldn't have had the public talking about the practice of medicine and about commercialized medicine, and of course prior to that time things had been very peaceful; but Morris Fishbein, Editor of the American Medical Association paper, was making occasional talks out here and Morris Fishbein was telling them all about this patient-and-doctor relationship" (R. 298).

We refrain from expressing an opinion as to whether Dr. Sweeney overemphasized Dr. Fishbein's influence; but beyond a doubt Dr. Fishbein did influence doctors. But by 1941 Dr. Fishbein, his appearance, his speeches

and his influence, were (in Oregon) becoming a dim memory. Many doctors had in the meantime been admitted to the medical society who had never seen Dr. Fishbein—for that matter had never seen or heard of the Martzloff report, which the government emphasizes.

(f) *The changing times and customs.*

The simple fact is that while in 1936 the majority of doctors in Multnomah County were in favor of the disciplinary proceedings, in 1941 the majority were opposed. We have suggested above some of the reasons that we feel were influential in bringing about this change in attitude. We do not say that all these reasons appealed to all doctors. Some of them undoubtedly did, and some doctors perhaps had other reasons for changing their minds.

But whatever the reasons may be, it is clear that the attitude of doctors—like the attitude of people generally—had changed. Dr. Charles P. Wilson of Portland laid down some sound grassroots philosophy when he testified (R. 1716):

> "I know very definitely there has been a tremendous change in attitude toward all prepayment plans of medical care * * * Twenty years ago we didn't think much about prepaid plans of medical care * * *
>
> "There was quite a good deal of agitation when doctors tried to establish their own policies—their own organizations. Now in twenty years time they are an accepted procedure. But there is nothing strange about this, I think. It takes a certain time for things to dawn on people, for attitudes to change, for concepts to change, and certainly there is noth-

ing going to stay constant. Things that were true in 1928 and '30 and on up to '35 are not going to stay the same now as they were then."

And with respect to hospital associations themselves: "they change; their attitudes change."

This makes sense. It calls to mind the contrast between the literature of the thirties (the Martzloff report (Ex. 209; R. 2568), for instance), condemning the solicitation and advertising associated with "contract practice," and the current practices of OPS and other doctor-sponsored prepaid medical care organizations with their budgets for advertising and their staff of solicitors (R. 1685, 1687). And it explains, to a great extent at least, why for a decade no medical society has endeavored to prevent any of its members from "cooperating" with commercial hospital associations.

That the attitude of the public, and of the medical profession, too, has changed in the last fifteen years seems not to have occurred to government counsel. Intimating that the complaints of medical societies in 1936 of solicitation of patients by hospital associations was but a sham to conceal an economic motive, the government's brief says (p. 160): "The validity of the solicitation objection must be considered in the light of the fact that the very thing to which appellees objected in 1936 is now being done by their own organization, OPS."

It is true that OPS indulges in "institutional" advertising and solicitation. But although it seems to us that solicitation on behalf of a profit corporation employing a small group of doctors merits more censure than if con-

ducted on behalf of the great majority of doctors, including all who wish to join the organization, and offering services at moderate cost, the real explanation is that times and customs change and that medical societies have decided to face the facts of life.

2. The matter of "taking tickets".

(a) *What is it all about?*

We have here a most amazing spectacle. The resources of the anti-trust division—including at different times at least eleven attorneys and an undisclosed number of F.B.I. agents—have been devoted to proving a gigantic conspiracy. The main object of this conspiracy is said to be to coerce doctors into not "cooperating" with commercial hospital associations, by which is meant not "taking tickets" of such associations.

But the president and active manager of the largest of these associations, after forty years in the hospital association business, thirty years of it as general manager of National, testified that it is a matter of indifference to his association whether doctors take tickets or not. He so testified twice, once by deposition (R. 1754-5) and once at the trial (R. 585-7) as a government witness.

Then on rebuttal he changed his testimony (R. 2782).

On his deposition, he testified:

> "Q. So you haven't any preference, then, whether the doctor sends you the bill or sends the member the bill?
> A. That is correct" (R. 1754).

This testimony was given in May, 1949. Five months later, on October 24, he testified to the same effect, if anything, stronger:

> "Q. So it is possible for a doctor to cooperate with National without ever knowing that the member has a ticket?
>
> A. That is right, and I believe it is also possible for a doctor to get his money from us without even knowing it" (R. 586).

And again (R. 586):

> "Q. So, now, it is a matter of indifference to you, isn't it, whether the doctor accepts the ticket and sends in a bill or whether the member sends in the bill and obtains the check?
>
> A. I would say if the doctor rendered services to the member and gave him the information that was required on his bill, it would make no difference to us.
>
> Q. Make no difference to you?
>
> A. That is right."

But on February 10, 1950, when called on rebuttal, he had different ideas. His former testimony was only "a silly remark * * * a foolish remark" (R. 1874).

> "I have materially changed my views on that * * * I wouldn't say I was confused—but *I hadn't made an analysis of it, hadn't made a study of it * * * because I didn't expect the questions.* If given a chance to think it over I would certainly have answered differently because it makes a lot of difference " (R. 1875).

This General Manager of the country's largest commercial hospital association explained this about-face by saying that the "people in our office" had "pointed out

to me I had made a big mistake in my statement" (R. 1879).

Over seven years before, in February, 1942, the above manager had dictated a letter summarizing the arguments, persuasive arguments too, why National preferred that the bill be given to the patient rather than to the association (Ex. 2728; R. 7029).

That was the occasion of the only instance in which a general hospital notified National that it would not take tickets. At that time, in 1942, Mr. Bechtold was no more perturbed with that possibility than he was in his testimony in May or October, 1949.

"We prefer this plan," he said on that earlier occasion, "where the employee personally takes up his bill, since it gives us the advantage of the patient checking the services he has received and makes him more conscious of the benefits he has received under his contract. It also protects the hospital in cases not entitled to services at the association's expense who request the hospital to charge their accounts to the Association—which sometimes occurs. It is true it may not be as easy for a patient to enter the hospital under this plan, but no patient will be denied services to which he is entitled and will probably be more appreciative of his Protection by knowing the amount that is paid out for his care" (Ex. 2728, R. 7029).

While the above comments had reference to non-taking of tickets by a hospital, the arguments are equally persuasive when doctors are involved.

Dr. Moore, President of the second largest association, Industrial, also testified that except for additional work involved (R. 383-5) his company was neither embarrassed nor hampered by the practice of some doctors in not taking tickets (R. 388-9). We set forth extracts from his testimony:

> "Q. . . . What I am saying now is, that if a doctor cooperates with you by giving the patient an itemized bill that fully covers it so that you can tell whether the patient is covered, and the patient sends the bill to you and you pay the patient; that is all right, isn't it? A. Yes, that is alright, if the patient —if the doctor gave him the bill and he brought the bill to us and the bill was okeh and we would give the man the money.
>
> Q. And that doesn't embarras you in your—
>
> A. No, we get along under those conditions.
>
> Q. So that there are plenty of cases where the bill is sent in by the patient and you pay the patient? A. Yes.
>
> Q. And it doesn't in any way embarrass you or hamper you? A. No, we have cases, many of them that occur just that way" (R. 388-9).

In Exhibit 2720 (R. 7022) written by Mr. Page of National Hospital Association on October 14, 1946, a doctor was advised that under an individual or family contract he should not submit his bill to the association, but should send it to the patient—in other words, should not take the ticket. Mr. Bechtold reaffirmed the position taken in that letter. On individual and family contracts the association prefers that the doctors do not take tickets—although "don't particularly object" if they do (R. 1860-1, 1877).

We have carefully studied the forms of individual and family contracts in evidence, and we challenge anybody to give any sound reason why, with respect to ticket taking, there should be one policy for those contracts and a different policy for group contracts.

The explanation given by Mr. Bechtold is of course entirely devoid of logic. He said that the reason for this distinction was that "it is impossible to notify every doctor and have an understandng with every doctor" (R. 1877). The question is not whether it is impossible to notify every doctor to send in tickets; the question is why they prefer doctors not to take the tickets when family and individual contracts are involved and why they so notify doctors.

Another letter (Exhibit 2676; R. 6919) from Industrial, not National, asks a doctor not to send his bills to Industrial, but to the patients. But here there is a different reason. It applies whether the member is under a group or an individual contract. The "procedures employed," the letter says, "have reached proportions that can't be met by our insurance program."

Prior to the receipt in evidence of the above exhibits, several witnesses had testified that ticket taking was the *sine qua non* of "cooperation"—there were no exceptions. Indeed, much of the testimony complaining of the nontaking of tickets involved individual or family contracts (R. 667-73; Ex. 580-7; R. 3623-30; R. 699-708).

Indeed, prior to the receipt of the above evidence that tickets should not be taken by doctors on individual con-

tracts, government counsel had a former manager of Industrial's *individual* contract department testify of his difficulties in making sales because of alleged statements by doctors that they wouldn't take the tickets. So he quit his job; and notwithstanding the above evidence the government's brief says this was "because of the boycott" (Br. 141, n. 18).

And many persons had been advised by the associations that it was a matter of indifference with them which course was followed. Written notice to this effect had been sent to the District Manager of California-Oregon Power Company, at Klamath Falls (R. 860), to the Vice-President of Columbia Hudson Lumber Company in Clatsop County (R. 856), to the paymaster for Shepherd and Morris Lumber Company, also of Clatsop County—"Oh, yes, that is free choice to the individuals" —(R. 879), to the managing partner of Flegel Transfer and Storage Company of Roseburg, who is also mayor of Roseburg (R. 888).

But whether ticket taking is or is not important, it further develops, as we shall point out later, that more doctors take tickets of commercial hospital associations than belong to the doctors' own organization, Oregon Physicians' Service.

(b) *What is an indemnity contract?*

The big differences between the method of operations of hospital associations prior to 1941 and their operations since then are (1) the shift from the closed panel (a few selected doctors) to the open panel (each mem-

ber having a free choice of physician), and (2) as a corollary to the open panel, the contract is no longer an agreement to furnish medical services but is an agreement to indemnify for medical expenses incurred.

In other words, the "ticket" which the member has does not, as formerly, entitle the member to service. It entitles him only to limited reimbursement for medical expense. But there seems to have been a carry-over in thought from the old days. The old idea that the ticket was a valid requisition for services—that the doctor is working for the commercial association and not for the patient—has, as the testimony in this case so clearly shows, not entirely disappeared.

On this point even Dr. Moore, Industrial's President and Medical Director, seemed confused. He agreed that his company's contract was one of indemnity "very largely" (R. 380-1), but he believes that members thought that tickets should entitle them to "get service" (R. 415-6).

Mr. Bechtold of National seemed clear enough in his deposition and in his first testimony at the trial. But on rebuttal, his views on this subject as well as on others had changed (R. 1877-8). Thus he formerly thought that the circumstances of the case and the doctor's conscience should determine the doctor's fee. A mimeographed letter sent out to doctors March 18, 1940, assured them that "the Association is not presuming to tell the doctor what his charge shall be" (Ex. 2683; R. 6936; see also R. 600), but in his rebuttal testimony he said he believed that, under "a practice and custom," the ticket "is his pay" (R. 1878).

That government counsel are utterly confused on this matter is manifest from the following quotation from their brief (p. 166):

> "The Oregon prepaid medical care plans, both commercial and medical society sponsored, deal with the financial aspects of a medical care program. They sell medical care policies, *make contractual arrangements with the participating physicians and hospitals,* . . . " (Italics added.)

As applied to commercial hospital associations since 1940, the italicized statement is 100% wrong. The president of National testified as follows:

> "A. We have no contracts with doctors. Q. You have no contracts with doctors? A. No.
>
> Q. Do you have any doctors on your payroll? A. We have two or three doctors on retainers for the general work, but, beyond that, there is no one on our payroll . . . .
>
> * * * * *
>
> Q. So that whatever relationship you have with these doctors does not arise out of any contracts? A. That is right" (R. 1753).

And testimony to the same effect by the manager of Industrial is as follows:

> "Q. How many doctors in Oregon would you say including Dr. Moore, that you have agreements with, oral or written or gentlemen's agreements or legal agreements or any kind of agreement, that they would take care of your patients and send in tickets? A. We have none.
>
> Q. None except those two? A. No. Down at Westport we have a doctor, and we have a branch office and equipment, and we pay him a retainer, and we hope our people will go to him, but under

> their contract everyone can bypass him. He lives in a lumber company's house and he is looked on as the doctor for that community" (R. 458-9).

The town of Westport referred to in the quotation just given has a population of about 650.

The above misconception under which government counsel who prepared the brief have been laboring that commercial hospital associations have contracts with Oregon doctors to render services to the association's members undoubtedly is responsible for many other erroneous impressions of that system which have found their way into the brief. Naturally when a person with coverage by a hospital association obtains treatment from a physician all aspects of the situation—the legal relationships, the loyalties, divided or undivided, the obligations with respect to "tickets"—are utterly different if the physician has a contract with the patient's hospital association to render these services than they are if he has not. If there is no contractual arrangement, then the plan actually does not, as government counsel state it does (Br. 52) "involve a system known as 'taking tickets' " nor a system in which the doctor "submits a report to the association on services rendered, and the association pays him *according to the fee schedule*" (*Ibid.* Italics added.). If the doctor under such circumstances takes the ticket, it is purely a matter of personal accommodation and nothing more—it is not because he is operating under some plan which "involves" such a procedure.

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The expression "prepaid medical care plans" while used indiscriminately in this case by counsel of both sides and by the Court, is, as applied to commercial hospital associations, a misnomer.

In the nature of things protection against doctor and hospital bills can involve either one of two types of agreements, either an agreement for medical and hospital *services*, or an agreement for *indemnity* against the expenses of such services. The hospital associations as they now operate have agreements of the latter type. So do many of the old line insurance companies, in connection with which no one has ever suggested there should be any "ticket taking." The Oregon Physicians Service and other doctor-sponsored plans are of the former type, agreements for the service.

A commercial organization if it provides for services rather than indemnity is itself, from a legal standpoint, practicing medicine. In such a case the doctor is employed by, and works for, the association. See *Guisti v. C. H. Weston Co.*, 165 Or. 525, 108 P. (2) 1010. In the present indemnity type of the hospital associations' contracts, the doctor, contrary to government counsel's misconception (Br. 53), properly should regard the patient "as a private patient."

And of course there is no substance to the contention that in such an *indemnity* type of organization, ticket taking is necessary to successful operation, for the old line insurance companies succeed with their accident and health policies with provisions for medical and hospital indemnity.

The shift from the old type of limited panel service contract to the new open panel "free choice of physician" indemnity contract has, as the witnesses testified, been an evolutionary process (see Moore, R. 379). It has resulted in a "betterment of the service," has satisfied the membership of unions in their demand for free choice of physicians, has improved the stature of hospital associations in this state, and generally is in the public interest (Moore, R. 379-80, 414; Bechtold, R. 606, 1756-7; Weston, R. 692).

There are of course several times as many doctors taking tickets now as there were under the old limited panel system. In those days, more doctors, in some communities at least, wished to work for hospital associations than the hospital associations wanted to take. Under this new scheme of things, the important change is that doctors do not work for hospital associations at all.

But a member cannot have both a "free choice of physician" and a ticket which will itself entitle him to service. The former outlaws the latter. The doctor under the new scheme of things no longer works for the hospital association. He works for his patient. If he "takes the ticket" he does so as the agent of the patient. And in so doing he may ultimately not be paid his fee, or only a part of it.

What we have just said is made clear in the contracts in use by hospital associations. A number of National contracts are in evidence, Exhibits 1808 to 1837 (R. 5428-94). In the respects now being discussed, they are all similar. As an illustration, we take Exhibit 1836

(R. 5490). Section IV (R. 5492) relates to "Claims and Proof of Rights to Benefits." It not only provides that the claim and proof shall be filed by the member, not by the doctor, but has this express provision:

> "(F) * * * The obligations of the Association under this contract are personal to the Member and no other person shall have any claim, or any rights to benefits hereunder."

The National contracts to which we have just been referring are the individual and family contracts. There seems not to be a current group contract of National in evidence. The one in evidence most recently in use seems to be Exhibit 72 (R. 2180) which was in use "about 1946 and '47, I believe" (R. 578).

While the form (Ex. 72; R. 2180) is different, the group contract like the individual and family contracts makes it clear that the company's obligations are to the employee only. Under "Provisions and Limitations" (R. 2186), there are first some general provisions, concerning which Mr. Bechtold testified (R. 637-8), giving the Association the right to designate physicians, and in the event they fail so to designate them then the member may consult any licensed physician (of course this is not exactly "free choice of physician"). Nowhere does it indicate that the physician is to send his bill to the association, but the opposite is provided. The end of the second paragraph directs:

> ". . . provided that the employee shall take up itemized statements from the attending doctor and/or hospital and forward them to the Association to-

gether with the employee's 'hospital ticket' and such other information as the Association shall require" (R. 2186).

The next to the last paragraph of this section does indeed make it "optional with the Association to make such payments to the employee or to the doctor" (R. 2187). But note that it is entirely "optional with the Association"; and to make it clear that the association does not obligate itself to doctors, the sentence concludes:

> " . . . it being understood, however, that the Association's responsibility is to the employee" (R. 2187).

Lest it might be said that National would not take advantage of this provision if a claim were made by a doctor, we suggest a study of Exhibit 1876, a letter of December 11, 1947 (R. 6739), in which National refused to pay a widow of the deceased member, on relief, the bill for doctor's services rendered deceased, on the ground that the obligation of the association was only to the administrator of the estate. It later, in 1948, paid, but only in part, for these services which had been rendered in 1944 (R. 1613-5).

Or perhaps even more to the point, the letter from Mr. Page, of National, dated October 24, 1949, just three days before he took the stand in this case and testified about the great hardship upon National caused by the failure of doctors to send their bills to National (R. 806, 807). This letter was addressed to a Portland doctor who had asked National to pay for services rendered a Na-

tional member. In it National refused to pay for these services, not because there was no coverage, but because "the service was rendered without authority from this Association to provide at its expense," and suggested that if the member "feels he has a claim, he can present it to the Association" (Ex. 2708; R. 6994).

And of course there still are many types of situations where the doctor, when he sends his bill to the Association, is not paid (R. 382, 602, 1989-90).

(c) *Alleged hardship on members.*

As pointed out above, the "hardship" on the members seems to arise from the phobia that the ticket entitles the member to service, not merely to indemnity. As one member complained (Ex. 11, reverse side; R. 2122):

"I have to do all the red tape."

The government brief refers to the "disappointment, annoyance, and work for the patient" resulting from the failure of doctor to take the ticket (Br. 53). We believe it is abundantly clear from the record that hospital associations have done nothing to clear up the misapprehension in so many of their members' minds that the doctor is under some obligation to handle this "red tape," that he, as was the case in the old days, works for the association. The patients, in other words, are under the same misapprehension as are government counsel (Br. 166), discussed above, that hospital associations are under contractual arrangements with the doctors.

But notwithstanding the phobia, and the red tape, the hardship on the member cannot be as bad as has been pictured (Br. 53). Between 1940 and 1948 the income of Industrial increased from $407,970.00 to $1,-010,261.00; that of National from $567,901.00 to $1,562,-301.00 (Ex. 1265; R. 4829; Ex. 1267; R. 4866).

Out of a total of several hundred group contracts held by Industrial (508 in 1948, see Ex. 445; R. 7369), Mr. Brunkow, Industrial Manager, could only feel safe in estimating that since 1941 not over twenty-five contracts were lost to OPS (R. 436, 460-1). Bechtold believed his company had lost more than tewnty-five contracts (R. 571). In 1948 his association had 840 of them (R. 7346).

We are indebted to government counsel for their painstaking analysis of more credible evidence than the bare opinions of the two managers set forth above. As pointed out in an early portion of this brief, government counsel have concluded that at most there have been thirty "verifiable accounts" lost by hospital associations, of which "more than fifteen have been lost since 1945" (Br. 67-8).

(d) *Alleged hardship on hospital associations.*

We have already discussed some of the alleged hardships on hospital associations arising by reason of the failure of some doctors not to take tickets. As we have seen, the hospital associations seem to be very uncertain as to whether they are aided or injured by the fact that some doctors do not take tickets. Seemingly they need-

ed, even after the trial started, a careful use of apothecary's scales to weigh the advantages against the disadvantages. Though the hospital association officials seem not to be in entire agreement on the subject, the concensus of opinion among them, as we have noted, seems to be that in some types of contracts—and in some types of situations under all contracts—they prefer that doctors do not take tickets; and in other types of contracts, and situations, they prefer that doctors do take them.

The hardships testified to are of two kinds. The first is the loss of business by reason of doctors refusing to take tickets, but as we have just pointed out, during the entire period of this alleged conspiracy the loss of business due to this alleged "noncooperation" has been negligible.

The government brief refers to two small companies, the Pumphrey Company and Weston Company. In 1936 these companies had, respectively, gross incomes of $61,-511.00 and $79,168.00. They eventually went out of business. Although, as the government's brief states (p. 50), the Weston Company went out of business "after it had lost the services of these two staff doctors," there is no testimony that the loss of these services was the cause.

As a matter of fact, Mr. Weston testified, he went into a different and better type of prepaid medical care business. His company is now writing policies "in Aetna, Continental or Commercial Casualty, or United Pacific

Insurance Company; write in all of those companies." The type of policy which he is now writing "is an advancement in service insofar as it permits the patient to go to any doctor in the United States or any hospital in the United States. They are not limited to any doctor or any hospital." He added that "that is the trend of today" (R. 692). Insofar as the testimony discloses, his purpose of discontinuing his former type of business was to sell the better advanced type of contracts.

The next alleged hardship was in additional clerical help required.

This paper work, the "red tape," must be done by someone. As we shall point out hereinafter, when doctors do take tickets and send their bills to hospital associations they have a tremendous amount of additional work. This work imposed upon doctors is more than the additional clerical work which the hospital associations must assume when they reimburse members rather than pay doctors. Hospital associations do not pay doctors for this additional work. Those who feel that the cooperation which doctors should extend to hospital associations should include the payment for clerical work without reimbursement, may be impressed by this argument of hardship to associations. Frankly, it does not impress us.

(e) *Number of doctors who don't and number who do, take tickets.*

Mr. Brunkow, General Manager of Industrial Hospital Association, states that he and other employees of his company spent over two years in searching their rec-

ords for information for the government in this case (R. 418-9). In addition to that, in 1947 and the first half of 1948 he conducted a careful survey to determine the number of doctors who took tickets of his association. He testified that this survey disclosed that during this eighteen months' period there were over 1400 who took such tickets—these including not only doctors of medicine but "osteopaths, chiropractors, chiropodists, optometrists, naturopaths . . . everybody who called himself a doctor" (R. 445; see also Ex. 2737; R. 7040, a letter which refers only to doctors). He explained also that the number included doctors not only in the State of Oregon but in other states.

Documentary evidence in the case makes it possible for us to arrive at a rather close approximation of the number of Oregon doctors included in the "over 1400" who took tickets during that period of time.

The payments to doctors in other states increased greatly in 1948 over prior years, and in that year plaintiff's evidence is to the effect that there were 257 out of state doctors paid (Ex. 1445; R. 7371). Deducting this number from 1400 means that during the above period of time there were payments to over 1143 in Oregon.

Payments to chiropractors apparently equal about 1/10th of 1% of the total (Ex. 2696; R. 6971-2). The only evidence as to the percentage of other members of the healing arts other than doctors included in the 1400 is found in Exhibit 1742 (R. 7527). This exhibit discloses that among the 257 out of state persons to whom payments were made in 1948 were 13 dentists. No other

practitioners of healing arts were included. We believe it would be a generous estimate to say that not over 5% of those included in the 1143 were others than doctors of medicine.

This means that in the period in question—January 1, 1947, to June 30, 1948—there were over 1085 Oregon doctors who took tickets of Industrial Hospital Association, sent their bills to that association and accepted payment from it.

January 1, 1948, there were 952 cooperating physicians of OPS (Ex. 2186; R. 6589), and the greatest number during 1948 was 1015 (R. 1659). In other words, there were substantially more doctors taking tickets of Industrial Hospital Association than there were cooperating physicians of OPS.

In the year 1948 there were 1660 licensed physicians of Oregon, of whom 1210 were members of Oregon State Medical Society (R. 11T; Finding No. 50, R. 2029).

It should be borne in mind that the 1085 Oregon physicians were those who actually treated Industrial members, sent their bills to Industrial and accepted checks. It is obvious, as Mr. Brunkow testified, that during this period lots of doctors never had occasion to treat such members and accordingly to determine whether or not they would take tickets (R. 457).

On the other hand, the 1015 OPS cooperating physicians were merely on the list—like lawyers' names on law lists. The number on the list who didn't see OPS patients is unknown. At the trial two prominent doctors

were unable to recall whether their names were even on the list (R. 1230, 1267).

With respect to the hospital associations other than Industrial, the evidence is not clear as to the number of doctors who take tickets. However, in 1948 there was a total of $596,644.80 paid to doctors by National (Ex. 1443, sheet 9; R. 7352), as compared to $446,884.65 by Industrial (Ex. 1445, sheet 15; R. 7371).

In 1944, the President of Prudential wrote that "we have had no doctor in any town or city who has refused to accept out identification slips and bill us direct" (Ex. 858; R. 480).

In the two years that the staff of Industrial gathered information for the government, they also secured evidence as to the doctors who *did not* take tickets. From this information and other evidence obtained by FBI agents, Ex. 1853 (R. 5505) was prepared (R. 426, 443-5, 461). It is a list of eighty names on which somebody (whether one of the several attorneys or one of the FBI agents we do not know) had written that it was a list of doctors "who we have evidence of refusing tickets other than I.H.A. and who Brunkow *says* refused I.H.A. also." Twenty-three of these names are listed as being from Jackson and Clatsop Counties, although nine of these at the time of trial were either dead, moved from the county, or not in practice (R. 1012, 1065-6). The reason these nine are on the list is, we assume, that, as indicated on the exhibit itself, and as plaintiff's counsel assured us at the trial, the exhibit is not intended as a list of doctors who at any particular time were refusing tickets, but

merely "during this period of the complaint these doctors were refusing tickets," and that our contradictory evidence was "not relevant to the fact of whether during sometime during this period he refused tickets" (R. 1065).

The "period of the complaint" was approximately thirteen years.

So we may summarize the government's evidence as follows:

Eighty doctors at some time or other over a period of thirteen years have refused tickets both of the Industrial Hospital Association and one or more other hospital associations. (Frankly, we believe the evidence shows a few more than this.)

1085 Oregon doctors took tickets of Industrial Hospital Association between January 1, 1947, and June 30, 1948. (The total number who treated Industrial members during this time is not known.)

1045 Oregon doctors were at some time in 1948 willing to take OPS tickets if OPS patients presented themselves for treatment—in other words, were on the official list of OPS cooperating physicians.

In considering the above evidence, it should be kept in mind that of the licensed physicians in Oregon (there being 1660 in 1948) many in general practice had no occasion to treat a member of a hospital association during the above period. More important, there are many licensed physicians who because of their occupations or specialties, do not treat ailments covered by hospital

association contracts. The number has been estimated at from 300 to 350 (R. 1766-7).

Likewise, of the doctors who do, and of those who do not, take tickets there is no evidence as to the number who are members of their medical societies.

(f) *Why doctors do not take tickets.*

The charge is that the defendants, through coercion, intimidation, harrassment, threats, etc., have caused doctors in Oregon not to "cooperate" with commercial hospital associations—and by lack of cooperation it develops is meant failure to take tickets. We have just seen that the great majority of Oregon doctors do take these tickets. We now proceed to consider the reasons which have led others to decline to do so.

(1) *It is not because of medical society pressure.* It seems to us that the charge of coercion was largely if not entirely abandoned when the government withdrew the charge (R. 82) in its More Definite Statement (R. 63-7) that the long list of doctors there named had been "subjected to specific coercion, compulsion, harrassment, threats or pressure." This conclusion seems to be buttressed by the fact that the government had these doctors under subpoena but did not call them as witnesses (R. 7529-37).

At any rate, whether the government has abandoned this charge or not, the evidence is clear that there has been no such coercion or pressure, or even attempts, by medical societies to prevent doctors from taking tickets.

From all portions of the state, doctor members of

local medical societies have testified that there has been no pressure of any kind whatsoever nor discrimination by their medical societies against any doctor either to prevent him from cooperating with hospital associations or as punishment for having done so (R. 1042, 1048, 1053, 1062, 1066, 1070, 1080-1, 1089, 1248, 1298, 1375-6, 1386, 1406, 1457-8, 1475, 1563, 1619, 1735).

Many of the members of the Council of Oregon State Medical Society and Multnomah County Medical Society, including nine who themselves take tickets of commercial hospital associations, testified that since 1940 there have been no suggestions in council meetings that attempts be made to prevent doctors from thus cooperating (as to OSMS, see R. 1361, 1372-5, 1504, 1580, 1619-20, 1765; as to MCMS, see R. 1402-3, 1505-6, 1525-6, 1636, 1682, 1715-6, 1724, 1749, 1776, 1778; as to OSMS House of Delegates, see R. 1724).

Mr. Marshall, Manager of OPS, has participated in many meetings and conferences of county medical societies throughout the state, particularly between 1942 and 1946, and has never heard any proposal to attempt to prevent doctors from taking tickets (R. 1664-5).

We could if we wished stop here. For it is only necessary to find that the refusal of doctors to cooperate with commercial hospital associations is not due to coercion by medical societies. We shall, however, go further and discuss the reasons why doctors who do not take tickets—small in number—do not do so.

(2) *Don't want that kind of business.* When the hospital associations changed over from the old closed panel with few doctors working for hospital associations to the indemnity plan with free choice of physician, necessarily a large number of doctors throughout the state were presented tickets by their patients who had never theretofore had occasion to consider whether they wished to deal with commercial hospital associations. Naturally, it would be expected that many of them would turn down the tickets just because they didn't "want that kind of business." Many under such circumstances would not be aware of the type of contract outlining the coverage. Many who had been accustomed to filling out forms to enable patients to secure reimbursement from national insurance companies were naturally puzzled by this alien "ticket-taking" system. This type of doctor prefers to treat the patient "as his private patient" and does not wish to have a profit-making corporation even "take care of the *business* end of his medical problems" (Gov. Br. 166).

The government (R. 829-30) and the government's witnesses (R. 382) stressed during the trial that before a doctor performs services in reliance upon payment by a hospital association, he should ascertain from the association whether the patient is covered. In many cases the doctor does not know that the patient even has a ticket until the services are rendered. In many other cases the amount involved is small.

So, for all these reasons, it is clear that many a doctor just doesn't care to be bothered with the details in-

volved. Many, as we have seen, don't care for OPS either. In fact, more take Industrial Hospital tickets than OPS tickets.

(3) *The lesson of experience.* But the evidence is overwhelming that in the case of most doctors who refuse to "cooperate" with hospital associations, the refusal is based upon past experience. This is usually the experience of the doctor involved, though sometimes it is the experience of friends or associates which has come to the attention of the one involved. We have set forth in Appendix B excerpts from letters written by hospital associations and in Appendix C numerous quotations from the testimony of doctors, all disclosing the intolerable situation in which doctors found themselves when they became subject to the dictation and control of hospital associations in the practice of their profession. The doctors who refuse to deal with hospital associations do so not because of any coercion by anybody but because of their own individual experiences. They are rebelling against a system under which they were required to obtain authorization before proceeding with such types of treatment or operations as they believed their patients required (R. 1001, 1019-20, 1078-9, 1095, 1149-51, 1209, 1227-9, 1261-2, 1283-4, 1562, 1577, 1612-3, 1733); a system under which the amount of their bills was repeatedly questioned and reduced (R. 1002-3, 1077, 1090, 1168-9, 1186-90, 1201-2, 1209, 1578-9, 1595, 1602, 1734-5), or not paid at all (R. 1989-90); where in many instances they were nothing more than first aid men, the patients being required to come to Portland from Medford (R. 1004),

from Roseburg (R. 1211), from McMinnville (R. 1395-6). and other places (R. 1263, 1576-7, 1599, 1637); a system involving a limited panel of doctors, the hospital association and not the patient determining who the doctor should be (R. 1000, 1063, 1400, 1457, 1462, 1465, 1564, 1610, 1637, 1732).

Most of the doctors who at some time or other stopped taking tickets eventually returned to that practice, feeling that under the new type of indemnity contract the dangers of the old abuses were gone (R. 414). To a greater or less extent their hopes in this regard have been fulfilled (R. 1457, 1580), but there are still many who having freed themselves from their former intolerable situation, refuse to take even the first step to what might result in a return to their old bondage. Their reason is: "I know what would happen" (R. 1031).

Without asserting that in every respect they are surely right, we need but call attention to the evidence we have already discussed, particularly that even now hospital associations sometimes refuse to pay either because of "lack of coverage" (R. 382, 602) or because work is done without authorization (Ex. 2708; R. 6994); they continue to reduce the fees (R. 1364); they engage in "bickering back and forth" (R. 1368); and with doctors who "cooperate" with them "they are dictating to us what we can and cannot do" (R. 1369).

And it must be remembered that while the contracts of National Hospital Association on their face may indicate that members have a free choice of physician, it is not the contract but the ticket that the employee gets

that really counts. The ticket, in some cases at least (Ex. 1451; R. 5055, 5056, discussed at R. 637-8), tells him not that he has a free choice but that he must go to the doctors designated by the association. Mr. Bechtold, President of National, told us, "We reserve that right to designate the doctors," and that they "have a pretty good list of doctors who are no good" (R. 638). This list is kept in mind when they tell the members which doctors to consult (R. 638).

But, the government's brief argues (pp. 129-30), the doctors insistence that they will not work for hospital associations is "inadequate to explain the refusal of many doctors even to accept hospital association checks." It is of course true that many doctors have refused to take such checks. They fear that even a record of the acceptance of a check in a hospital association's possession will subject them to the risk of being held out as being bound by contractual relations with, and accordingly endorsing the practices of, these hospital associations and also being placed on the lists of such associations against their will. Thus one of the defendants, Dr. Martzloff, explained his refusal:

> "Because the checks that they send are an element of subterfuge, with the idea of getting a doctor's endorsement on a check and then to use that for publicity purposes to show that you are one of their employees or cooperating doctors" (R. 1441).

Dr. Fitzgibbon, another defendant, testified:

> "The object, I was told by those who had seen other men's names displayed as endorsements and

> on checks, was to get my name on a check or letter . . . with the idea of proving that I was cooperating with these organizations, when I was not really—when I really was not" (R. 1344).

It was, of course, desired publicity by hospital associations that some of the leaders in the profession endorsed their practices. Ex. 2704 (R. 6989-90) is a letter from Drs. Blair & Thatcher complaining to certain industries and to two medical societies that without their permission their names were included in a list of doctors attending patients for Industrial Hospital Association, under the heading of "Specialists." "We were not aware," the letter said, "that such a list existed until this information was received from St. Helens, Oregon."

(4) *The doctor's right to determine his fee.* In the private practice of medicine—when hospital associations are not involved—there is, generally speaking, no such thing as a schedule of fees. In determining a charge in any particular case, there is taken into consideration the experience and skill of the particular doctor, the nature, complexity and difficulty of the particular ailment, and the ability of the particular patient to pay. The President and Medical Director of Industrial Hospital Association, a doctor of long and varied experience, testified at some length on this subject (R. 391-3). The President and Manager of National said his company did not try to influence doctors as to their fees and had so advised them (Ex. 2683; R. 6936; R. 600), although on rebuttal he seemed, as already indicated, to shift his ground and state that the hospital ticket presented to the doctor "is his pay" (R. 1878). National has recently taken into

consideration the "ability to pay" principle by issuing a contract which provides for variable premiums and corresponding variable fees (R. 1861-3).

Now, as the government's brief points out (p. 89), the "commercial hospital associations generally have no income limitations in their contracts"; so that in the case of a subscriber in the high income brackets being treated by a doctor who takes tickets, the doctor must nevertheless accept the standard fee set forth in the hospital association's schedule.

For regardless of the type of contract involved, in making payments to doctors for services, or to patients as indemnity for doctors' bills, hospital associations (except for "variable" fees in the type of contract just mentioned) have rigid fee schedules. They cannot, or at least normally do not (Ex. 2694; R. 6968), take into consideration that "there is a difference in compound fractures" (R. 392).

Now, under the present indemnity form of contract a doctor treating a member of a hospital association is not in any way bound to this fee schedule. He is not—as was the doctor under the old system—under any contractual obligation to the hospital association. In fact, usually he has had no contact at all with the association. In the pre-1941 days, the doctor who was willing to work on the rigid fee schedule—engaging as it were in the wholesale practice of medicine—or willing to be a "cheap doctor"—got all the business. Some doctors were attracted to it, many others wanted none of that type of practice. Today, when a doctor in the latter class treats

a patient who is a member of a hospital association and feels that he is entitled to a fee larger than the association's schedule, he is in a dilemma.

The Director of the Industrial Hospital Association, agreeing that a doctor might very well be entitled to a much larger fee than his company's schedule (R. 385-6), appreciated this dilemma (R. 389-90). So did Bechtold, President of National (R. 600-1). If the doctor takes the ticket and bills the association, with a supplemental bill to the patient, there may be a strain in the doctor-patient relationship. Despite the terms of the contract, the patient may think his ticket entitles him to service, not merely to indemnity. This is the phobia discussed above.

Indeed under provisions of some of the Industrial (Ex. 86; R. 2229) and Prudential (Ex. 104; R. 2273) contracts it seems that if the doctor accepts the ticket and bills the association he waives any right to make an additional charge to the patient.

That this is so seems to be recognized by government counsel for one of the features that hospital association plans "involve" is that after the doctor performs the services he "in turn, submits a report to the association on services rendered, and the association pays him according to the fee schedule" (Br. 52).

It should be noted that there is no evidence whatsoever of any insistence on the part of doctors who accept the tickets of the hospital associations to endeavor to collect more than the fees prescribed by those associations. When it is considered that, by usual standards,

those fees are low, this is surprising. It is obvious that if doctors actually desired to injure hospital associations they could do so by charging additional amounts over the fee schedule to the patients, thus creating a situation where the subscribers obtained only partial protection under hospital associations, but total protection under OPS.

(5) *The burdensome "red tape."* We have discussed above the "hardship" on hospital associations by reason of doctors not "cooperating" by taking tickets. This "hardship" seems to consist in the main of the necessity for additional clerical help; and is of such magnitude that Mr. Bechtold was unaware of its existence until after the trial started when some of his subordinates set him right.

But neither the government attorneys nor the hospital association executives have considered the hardship on doctors. As we have pointed out above, as a practical matter if a doctor sends his bill to a hospital association, he must accept its fes. This means that he must make a study of all their contracts and their various schedules of fees. If he did this, he would find a great variety of contracts (see, e.g., Exhibits 77 to 100, 1808 to 1937; R. 2204 to 2264, 5428 to 5494), each one specifying what is and what is not covered. If he properly applied himself to studying them, he would hardly have time to practice medicine (R. 1368).

Before taking the ticket, however, and indeed, as government counsel have endeavored to impress upon us, even before rendering services, he should call the hospital association to ascertain if the individual is "covered" (R.

829; R. 1889-90). He should also—if he wishes fully to "cooperate"—determine whether there is involved the type of contract and the kind of situation in which the association prefers that he take the ticket.

This determination of coverage is not always easy. For it involves not only an interpretation of the contract but also a medical diagnosis of the ailment. Physical ailments, like legal concepts, sometimes overlap or merge. Witness the following explanation by government counsel to the court: "We are trying to show that in this particular case this lady was referred to the Hemingway Clinic as suffering from a certain condition. The Clinic diagnosed her to be suffering from an entirely different condition. Then the question came up with the National as to whether they were liable. They were liable if she suffered from one condition and they were not liable if she suffered from another" (R. 1368).

On the next page, the doctor also explained: " . . . they will pay for the detection of the ova of the parasite but not pay for the culture" (R. 1369).

Then after the services are rendered the real paper work, the "red tape" must be done. This paper work must be done by somebody. The failure of a doctor to take tickets may cause additional work in the clerical department of the hospital associations, but if the doctor takes tickets it involves additional work on his part or that of his assistant, or both.

Dr. Hemingway of Bend gave us a good description of this additional work. Each company has a different

form "some of them are quite a nuisance." Particularly in the case of National Hospital Association the forms "are excedingly topheavy because we give one report, and then, if we do a complete examination, we have to submit more reports; and so it takes at least two or three reports, at least, to wind up a case for them" (R. 1363-4). In fact, in the Hemingway Clinic consisting of six doctors this paper work "entails the time of an extra clerk, which is necessary if you have any amount of business to transact, in order to fill out these reports" (R. 1364).

Of course no extra compensation is allowed by the Hospital Associations for this paper work. The Eagles require their members to pay the doctor $1.00 for each such report (Ex. 1253; R. 4780; R. 782), but the Industrial and National make no such provision. Hospital associations can employ personnel trained in this particular line of work and who are supposedly familiar with the various contracts. The assistant of the average doctor is trained as a nurse, not as a bookkeeper or clerk. One would think that hospital associations would wish to relieve the doctors of these burdensome details. Apparently the goodwill of the medical profession is not looked upon as an asset by hospital associations.

II. MISCELLANEOUS OTHER TYPES OF ALLEGED IMPROPER CONDUCT

Thus far we have principally been discussing the charge that Oregon doctors improperly and unlawfully refuse to cooperate with commercial hospital associations. There are other charges made in the brief which we shall briefly answer.

A. Alleged Control of Hospital Relations

Although directed to do so by the Court, government counsel were unable either in their original more definite statement, or in either of the four supplements thereto (R. 12-81), to give the name of any doctor who had "been restricted or excluded from access to hospital facilities by defendants' conduct" or of any hospital "from access to the facilities of which doctors were restricted and excluded by the conduct of defendants" (R. 54).

Nevertheless, the government still insists that defendants have throughout the thirteen years of the conspiracy endeavored to accomplish just that result. They cite a group of motions, resolutions and reports (Br. 70-1), the latest of which was in 1936, to endeavor to prove their point. The first of these, a recommendation of the Martzloff report, as the evidence affirmatively shows, was abandoned. nothing ever being done to carry it out (R. 1433). The rest of these resolutions and reports do not refer to cooperation with hospital associations, being general in their nature with respect to society membership and the code of ethics.

One of these was a resolution of the American Medical Association, submitted by defendant Dr. Fitzgibbon. It says nothing about hospital associations' prepaid medical care plans or anything of the sort. At the trial government counsel in cross-examining Dr. Fitzgibbon referred to it as an endeavor to make it a violation of medical ethics "for hospitals to take the patients of doctors who had secured their patients in an unethical manner," but as the doctor replied:

> "I think you have distorted it. I believe you'd better read the resolution" (R. 1355).

Attention is called (Br. 71) to the fact that Vanport Hospital while operated by OPS limited its staff privileges of OPS doctors. As we hereinbefore have pointed out, this hospital was government-owned and used for the care of shipyard workers, all of whom were covered by OPS contracts. There was accordingly no reason for doctors not members of OPS to have staff privileges. Later this hospital was taken on by the Permanente group. Although this group of doctors have their own hospital, many of them are admitted to the staff of one of Portland's general hospitals, the Hahnemann (R. 1507).

The only hospitals in the State of Oregon operated by any medical society group are two hospitals in Klamath Falls owned by Klamath Medical Service Bureau. And they admit without discrimination doctors and patients of commercial hospital associations (R. 1405). (The "profit" of this group referred to in the government brief (p. 169, n. 36) is from these hospitals.)

The brief also (71-2) refers to a letter of December, 1945, signed by Dr. Shea with a notation on it by Dr. Fitzgibbon; but as hereinbefore pointed out, this hearsay document is not subject to the construction that either one of these doctors was in the slightest influenced by hospital association cooperation in determining the admissibility of a doctor to the staff.

As hereinbefore pointed out, the four hospitals of Coos and Curry counties referred to on pages 72-3 are small private hospitals, each operated by one or two doctors.

On the other hand, Exhibit 2705 (R. 6990) shows the extent to which hospital associations demanded special favors from hospitals. It is a form of agreement whereby the hospital signing it would give to Industrial Hospital Association the exclusive right to use its name in connection with the sale of prepaid hospital care and would "refuse to accept patients from any other person, organization, company or association that may promote or sell to the public hospital care under a similar budget or prepayment plan." It provided for rates not in excess of $5.00 per day for private rooms, $3.00 per day for ward, and for additional accommodations Industrial was to receive a discount of 20% from the customary charge.

At one time the general hospitals of Portland did have under consideration the question of refusing to extend credit to hospital associations by taking their tickets. This was not because of any antagonism toward those associations but because very often after treating patients for a long period of time they had denied liability (Ex.

2733, R. 7034). Their experience in this regard did not differ from that of doctors.

Furthermore, the hospitals' proposal was not directed at commercial hospital associations alone but included also doctor-sponsored organizations. A resolution was eventually passed to the effect that the hospitals would send out notices that they would give no more credit (Ex. 2734, R. 7036). But the surprising thing is that the only organization to which notice was sent was defendant Oregon Physicians Service. Even here the matter was soon straightened out (R. 1408-10) and except for that little episode no hospital refused to extend credit to hospital associations (R. 654). So that our position may not be misunderstood, we wish to add that the hospitals would have been fully justified had they adopted the course of refusing to extend this credit.

It seems to us that the testimony of Mr. Bechtold, President of National, also completely refutes the government's contentions. In 1940 he wrote the Sister Superior of St. Vincents Hospital (Ex. 2732, R. 7033) expressing concern over information he had received that a "hospital insurance system" might be adopted by hospitals. He expressed the hope that "in view of our long pleasant relations" St. Vincent would not be a party to any such plan "that might injure us."

Explaining the above letter, Mr. Bechtold testified that his relations not only with St. Vincents but with all other Oregon hospitals had always been "just splendid . . . very pleasant" (R. 1883). In fact, while he denied that for the last ten or fifteen years his association had

received special rates from hospitals, lower than those charged the general public, he did not deny that prior thereto such had been the case. He explained this by saying that "all the hospitals appreciated not only the National Hospital Association but the Industrial and the other organizations, the advantages they received from us, and it is possible that they themselves have given special consideration to us" (R. 1881-2).

B. The McMinnville Cooperative

It is difficult to understand just what it is that the government thinks is proven by the hearsay evidence on the proposed McMinnville Cooperative (Br. 80-1). All it tells us is that a cooperative was proposed and later abandoned. The hearsay testimony is just as consistent with the inability of the promoters to raise the necessary funds, as with any other reason for its abandonment. The doctor referred to who "appeared interested" is Dr. Herringer. The other is Dr. Huckleberry. Neither of them was called by the government. It seems that two subpoenas were issued for Dr. Herringer (R. 7532). He was served with one of them and the other has a notation that "ptff's atty. requested nonservice." At any rate, government counsel were satisfied, despite our objections, to submit the matter purely on hearsay.

C. Medical Services to Fraternal Organizations

On page 50 of government's brief reference is made to a meeting by a doctor with one of Multnomah Soci-

ety's committees. The doctor was asked to "explain his contract practice with the Eagles" and he later removed from the cover of the Eagles booklet names of other physicians to "correct any implication that he was running a panel medical service." On page 133, there are some references to Lane County and Jackson County Societies' objections to Eagles and Moose medical systems. These organizations' medical arrangements are also discussed on pages 74-6, it being pointed out there that they care for their membership through a system by which the members receive "medical care without charge."

Then, on page 150, there is a quotation from appellees' incomplete brief filed with the District Court.

In the preparation of that incomplete brief, we were referring, as is apparent, to the first occasion above mentioned, the Portland situation in which the Eagles' physician removed objectionable matter from the cover of the booklet. With that explanation, what follows is a verbatim copy of what was stated on this subject in the former brief, excluding only references to the government's brief filed in the District Court:

A member of the fraternal order of Eagles and also his wife and minor children, as long as he pays his regular $13.00 per year dues, are entitled in addition to all the other benefits of membership to certain limited medical services. The extent of these services is set forth, though not very clearly, in Exhibits 1253 and 1254 (R. 4779, 4781). Apparently office calls, limited house calls, hospital calls and "minor surgical work" are included.

Each local lodge or aerie has a medical director or, as he is known, the "aerie physician." For the services thus rendered by the aerie physician to the members and their families the physician is paid 50¢ per member per quarter (Ex. 1254, page 5, paragraph 5, R. 4780). Thus, for services to each member of a family of five the physician receives 10¢ per quarter, or 40c per year. Widows and orphans of deceased members are entitled to these services if they pay $2.00 per year.

Members are urged not to call the physician unless they are in actual need and not to call him "because you feel the service is free." In capital letters the pamphlet, page 4, urges members to give the doctor "their patronage" in all cases in which their membership does not entitle them to service, for which the aerie physician makes charges, "in order to compensate him for the time and trouble he takes in giving the regular service." The Moose Lodge has a similar system (Ex. 2014, R. 6133).

For reasons familiar to lawyers as well as to doctors, this box-top, something-for-nothing method of dispensing professional services is contrary to the code of ethics of the medical profession. The doctors' code in this respect is similar to Rules 2 and 3 of the Canons of Professional Ethics of the American Bar Association and Rule 3 of the Oregon State Bar Rules of Professional Conduct. If under similar arrangements the Eagles had an "aerie lawyer," he would be promptly disciplined.

The medical profession attempts to induce doctors to comply with this code of ethics.

The doctors of Oregon maintain that they have the right to enforce this ethical principle by methods such as the evidence in this case shows they have utilized. They will continue to do so unless the Court tells them they are in error.

D. Industrial Contract Practice

This charge against the doctors is based exclusively on a series of articles appearing in *Northwest Medicine* in 1944 and 1945 (Br. 77-9, 134). As has heretofore been pointed out, the articles in *Northwest Medicine* have never been intended to be other than the personal views of the contributors; certainly they have been in no sense official pronouncements of medical society policy. Except for the fact that one of the articles refers to action of the house of delegates of the State Society, this portion of the brief would be disregarded. That action was simply a statement of the position of the house of delegates that railroad employees in being treated by doctors should have "private patient status," and the "insistance for adoption of this policy was led by doctors who hold or recently held contracts with some railroad."

That there is nothing in the nature of a conspiracy would seem to be clearly evidenced by the fact that at the time of the trial in this case the chairman of the board of medical examiners and also another member of that board were engaged in this type of industrial contract practice (R. 784-5), although appointments to this board are made upon the recommendation of the state medical society (O.C.L.A., Sec. 54-911). For that matter, the

president of Multnomah County Medical Society at the time of the trial of this case was a member of the clinic which handles all medical and surgical services for one of the railroads (R. 1494).

Dr. Besson, brother of defendant Besson, though closely associated with Industrial Hospital Association during a large part of his practice (R. 1501-2, 1503-4), was a member of the State Board of Medical Examiners for twenty years, a portion of this time as president (R. 1504).

III. CHARGES OF IMPROPER RESTRAINTS IN ORGANIZATION AND CONDUCT OF THE DOCTORS' PLAN OF PREPAID MEDICINE

The government brief also charges (pp. 83-92, 135-40) that the doctors have not only restrained commercial organizations but have restrained each other. These restraints are labeled "allocation of territories" and "limitations of coverage." The brief insists that when doctors embark upon an experiment of selling their services upon a prepaid basis there should be indiscriminate competition for the sale of each other's services. That is, as we understand the contention, the doctors throughout the state should, for example, compete with each other and with the doctors of X County for the sale of the services of the doctors of X County to their patients. Government counsel believe further that the requirements of the

Sherman Act are satisfied in such a situation only if the doctors of Y County in an endeavor to prevail in selling X County doctors' services to the people of X County add additional services and include commodities—e.g., hospital services, drugs and medicine.

A. The Purpose of Doctor-Sponsored Plans

With all deference to learned counsel, their proposals boil down to the proposition that doctors' services can be hawked about in the market place like pots and pans and vegetables. After reading their brief, one is more convinced than ever that services of learned professions are not commerce, nor the members thereof engaged in trade.

Contrast the concept as set forth in government's brief with that of the Martzloff report of 1935 which government counsel so severely condemn (Br. 26-9). That report pointed out that a large majority of the doctors believed that the medical profession owed a moral obligation to the community to provide a plan for the medical care of the low wage earners (R. 2575). It recommended that such a plan be undertaken. "The philanthropic motive," the committee urged, "should govern throughout and the plan should be considered solely as an attempt to carry out the century-old tradition of the medical profession to care for all classes of the community in acordance with their ability to pay" (R. 2578).

That is what the doctors are endeavoring to do. They are not interested in the profits to be gained from the

"business" of selling "prepaid medical care." They are interested in providing the best care possible for their patients under a system by which the cost thereof will result in the least burden to those patients. They much prefer that the sale of other services—such as of hospitals and nurses, be left to those professions, and the sale of drugs and medicine to the druggists.

Their cooperative endeavor to give the best of service with a wide choice of physicians, at low cost, has met with universal approval. They are encouraged by the fact that their organization, Oregon Physicians Service, is now the leader in the sale of prepaid medical care contracts (see government's br. p. 144), although they do not in the slightest begrudge the great increases in sales enjoyed by their competitors (see R. 4810, 4866).

B. "Allocation of Territories"

It is obnoxious to doctors to have their services sold without their consent. This was one of the more objectionable features of the commercial hospital associations in the thirties. This is also one of the reasons why we cannot agree with government counsel that any doctor should feel under obligation to "take tickets" of i.e., to work for, a hospital association with which he has made no agreement whatever.

So neither OPS nor the doctors of Y County have gone to X County to sell the services of the doctors of that county to their own patients unless those doctors have been willing that they do so. It so happens that throughout the state every county has a system of doc-

tor-sponsored prepaid medical care, either OPS or a local plan. But that is because after listening to the arguments, the doctors were convinced.

In any event, this is not "restraint of trade or commerce among the several states." Even if this were a case of sales of commodities, such "allocation of territory" within a single state does not violate the Sherman Act. *Addyston Pipe and Steel Co. v. United States,* 175 U.S. 211, 247.

C. "Limitations on Coverage"

If all the doctors of Oregon in endeavoring to provide these services in a manner to achieve the objectives set forth above agree that they will sell only doctors' services, and that their prepaid contracts shall be limited to low income groups, certainly there can be no objection. This is so because (1) it is in the public interest that their efforts be concentrated on the services which they are trained best to give, (2) they are not engaged in trade or commerce, and (3) the activities are all within a single state.

But in addition to that, all the government's brief points out is that certain alleged policies were adopted by the State Medical Society. Neither local medical societies nor local doctor-sponsored plans are in any way bound by these so-called state policies, which are only expressions of the views of the State Council who from time to time may be in office. Nor have the local groups followed them, except to the extent that after consideration they agreed with those policies.

IV. LEGAL ASPECTS OF CONDUCT OF DEFENDANTS

A. Interstate Commerce

1. Practice of medicine is not trade or commerce.

The grant of congressional power under which Sec. 1 of the Sherman Act was passed (Constitution, Sec. 8, Clause 3) gives to Congress the right "to regulate Commerce . . . among the several States, . . . " It does not grant to Congress the right to "regulate trade." "Trade" is a word of rather broad meaning, broader than the word "commerce." One of its meanings, however, is synonymous with a shade of meaning of "commerce"—"to engage in barter or the purchase and sale of goods."

Sec. 1 of the Sherman Act purports to prohibit contracts "in restraint of Trade or Commerce among the several States." Of course it is elementary that insofar as this statute may purport to apply to something other than the regulation of "commerce" it is to that extent invalid.

For this reason, the word "trade" as used in Sec. 1 must necessarily take such meaning as is included in the constitutional grant of power. In *Atlantic Cleaners and Dyers v. United States*, 286 U.S. 427, 434, the court in referring to sec. 1 of the act said that:

> "It may be that the words 'trade' and 'commerce' are there to be regarded as synonymous."

We submit that upon reflection the Court must conclude that such necessarily is the case.

In the *Atlantic Cleaners* case, just cited, the Court contrasted the meaning of the words "trade and commerce" as used in sec. 3 of the Act with the same words as used in sec. 1 and held that the meaning in sec. 3 was much broader than in sec. 1. It accordingly held that price fixing agreements by cleaners and dyers in the District of Columbia came within the prohibition of sec. 3, but expressed no opinion as to whether the same activities would be held to be included under sec. 1.

In *United States v. National Association of Real Estate Boards,* 339 U.S. 485, the court held that under sec. 3 of the Act agreement of real estate brokers fixing uniform charges for services were prohibited. It is noticed however that the court repeatedly in discussing the question referred to the word "trade" as "within the meaning of Sec. 3 of the Act." Cases giving apparently contrary meanings to Sec. 1 of the Act were dismissed by the Court as not pertinent because "we are concerned here not with interstate commerce but with trade or commerce in the District of Columbia" (p. 492).

In discussing the meaning of the word "trade" in Sec. 3 the Court said it would not "intimate an opinion on the correctness of the application of the term to the professions" (p. 492). Mr. Justice Jackson dissented on the ground that it is impossible to distinguish real estate brokerage "from the professions," and that the latter clearly are not within even Sec. 3 of the Act.

In the meantime, the court in *American Medical Association v. United States,* 317 U.S. 519, had declined to pass on the question as to whether the practice of

medicine was "trade or commerce" within Sec. 3 of the Act. It felt that that case could be disposed of on the basis that what the indictment really charged was an "obstruction and restraint of the business of group health" (317 U.S. at 528).

In each of these cases much of the argument revolved around Mr. Justice Story's opinion in "The Nymph", 1 Sumn 516, in which he held that in the Coasting and Fishery Act the word "trade" was used in a broad sense, but that even there it did not include the occupation of one "in the liberal arts or in the learned professions."

Whatever may be their meaning in Section 3, it would seem clear the words "trade or commerce" in Section 1 cannot include the practice of a profession. Nor is a profession "commerce" within the constitutional grant to Congress "to regulate commerce . . . among the several States."

Of course in view of this Court's opinion in the *American Medical* case, we cannot deny that some of the charges against defendants involve alleged restraint of something other than the practice of medicine, that is, the business of commercial hospital associations. Many of the charges, however—refusal to take tickets, alleged allocation of territories, fee schedules, etc.—do involve the practice of medicine. And we submit that when doctors sell their own services the sale cannot be disassociated from the rendering of the services for the purpose of condemning one and not the other. This is not what was involved in the *American Medical case*.

2. There has been no restraint of commerce "among the several states".

The question here is whether there has been a combination "in restraint of trade or commerce among the several States." The question is not, as the government's brief assumes, whether conduct on the part of some of the defendants in some indirect or remote manner "involved or affected" interstate commerce (Br. 99), or is "within the ambit of the Federal commerce power" (185).

For by a long line of decisions this court has held that mere local activity—where a "local motive" predominates—is not "restraint of trade or commerce among the several states." This is true even though what is done may have an indirect, even though serious, effect upon such commerce.

This Court, in *United Mine Workers of America v. Coronado Coal Co.*, 259 U.S. 344, 408, in which the rule just stated was re-enunciated, indeed pointed out "that if Congress deems certain recurring practices, though not really part of interstate commerce, likely to obstruct, restrain or burden it, it has the power to subject them to national supervision and restraint."

Congress later did just that; and this Court in *National Labor Relations Board v. Jones and Laughlin*, 301 U.S. 1, 40, in holding valid legislation regulating local activities which "affect" interstate commerce, adverted to the above language in the first *Coronado Coal* case and pointed out that since that decision Congress, by the use of appropriate language, had gone further than in the

Sherman Act and was regulating certain local activities having only indirect effects upon interstate commerce.

Later, in *Federal Trade Commission v. Bunte Bros.*, 312 U.S. 349, 351, the Court pointed out that in addition to the National Labor Relations Act the Congress "in order to protect interstate commerce" had in other instances also "regulated activities which in isolation are merely local." But in each instance it had "normally conveyed its purpose explicitly." The Court however was there concerned with the meaning of Section 5 of the Federal Trade Commission Act (15 U.S.C.A., sec. 45) directed toward "unfair methods of competition in commerce" and it held, page 354, that "unfair methods of competition in [interstate] commerce could not be construed to mean 'unfair methods of competition in any way affecting interstate commerce.' "

The first *Coronado Coal Company* case, referred to above, was followed in *Industrial Association of San Francisco v. United States*, 268 U.S. 64. That case involved an association of building contractors who endeavored to counteract union activities and to coerce an open shop by a "permit system" limiting sales of certain materials to builders supporting their plan. But though some of the materials included within the "permit system" were from other states, the Court held there existed no violation of the Sherman Act.

"The thing aimed at and sought to be attained," by defendants' activities, said the Court (268 U.S. at 77), "was not restraint of the interstate sale or shipment of commodities, but was a purely local matter." And again:

"The facts and circumstances which led to and accompanied the creation of the combination and the concert of action complained of . . . are 'ample to supply a full local motive for the conspiracy,' " quoting from the first *Coronado Coal* case.

The *Industrial Association* case repeatedly has been referred to with approval by subsequent decisions of this Court. Thus, in *Levering and Garrigues Company v. Morrin,* 289 U.S. 103 the Court held that no substantial Federal question was presented by the allegations of a bill to enjoin defendants from combining to maintain a closed shop by carrying on a boycott against complainants, even though the materials used in complainants' operations were transported from other states. This was because, although there were indirect restraints upon interstate commerce, "*Use* of the materials was purely a local matter, and the suppression thereof the result of a pursuit of a purely local aim" 289 U.S. at 107.

The *Industrial Association* case was again cited with approval in the *Jones and Laughlin* case, supra, 301 U.S. 1, in which the Court contrasted the reach of the Sherman Act with that of the National Labor Relations Act, 301 U.S. 1, 39-40.

The same construction of the Sherman Act was reaffirmed in *Apex Hosiery Company v. Leader,* 310 U.S. U.S. 469, in which respondents had engaged in an unlawful sitdown strike. They "intended to prevent petitioner's shipments in interstate commerce in the sense that respondents must be taken to have intended the natural and probable consequences of their acts" 310 U.S. at

485. But notwithstanding this and that the "effect on trade or commerce was to prevent substantial shipments interstate by the employer" (p. 487) there was no violation of the Sherman Act.

That Act, the Court said in the above case, "admittedly does not condemn all combinations and conspiracies which interrupt interstate transportation." And, finally, on pages 500-1: "Restraints on competition or on the course of trade in the merchandising of articles moving in interstate commerce is not enough, unless the restraint is shown to have or is intended to have an effect upon prices in the market or otherwise to deprive purchasers or consumers of the advantages which they derive from free competition."

The Court in the *Apex Hosiery* case, however, was careful to point out, 310 U.S. at 484, that actually the restraint upon interstate commerce was such "as to bring the acts of respondents by which the restriction was affected within the reach of the commerce power if Congress had seen fit to exercise it." In fact, as the Court pointed out, p. 485, the validity of the Wagner Act had been sustained even though the labor relations regulated by it "affected" interstate commerce in "situations no more closely related to the commerce than these, and where the interstate commerce affected was no greater in volume."

Other recent cases of this Court in which the doctrine of the first *Coronado Coal* and the *Industrial Association* cases was recognized are *United States v. Frankfort Distilleries,* 324 U.S. 293, 297, and *Mandeville Island Farms*

v. American Crystal Sugar Co., 334 U.S. 219, 234, n. 14.

The above, it seems to us, disposes of that portion of appellant's brief (pp. 182-93) in which the contention is made that the alleged conspiracy "involved and affected interstate commerce" (p. 182) and the claim that that is sufficient to constitute violation of the Sherman Act. It is therefore unnecessary to consider the decisions cited therein, involving statutes such as the National Labor Relations Act.

The recent two cases of *Mandeville Island Farms, Inc. v. American Crystal Sugar Company*, 334 U.S. 219, and *United States v. Women's Sportswear Mfrs. Assn.*, 336 U.S. 460, cited on page 191, do, it is true, involve local activities, but activities that directly restrain interstate commerce. The gist of the holdings there, it seems to us, is the quotation in the brief, p. 191, from the *Women's Sportswear* case that:

> "Restraints, to be effective, do not have to be applied all along the line of movement of interstate commerce."

What we have said is not to the contrary; but the restraints must be *of interstate commerce*, not of local activites utilizing goods, for instance, which formerly came from another state. In the *Mandeville Farms* case, the restraint was as the goods were starting on the interstate movement, and in the *Women's Sportswear* case the goods had temporarily come to rest during the interstate movement.

Neither is *United States v. Southeastern Underwriter's Association,* 322 U.S. 533, contrary to our contentions. There the court stressed that the total assets of the modern insurance business exceeds $37,000,000,000, annual premiums over $6,000,000,000, and that "Perhaps no modern commercial enterprise directly affects so many persons in all walks of life as does the insurance business." A large share of the insurance business is concentrated in a comparatively few companies located, for the most part, in the financial centers of the east and premiums flow into those centers for investment. "This business," the Court said, "is not separated into forty-eight distinct territorial compartments which function in isolation from each other" (322 U.S. at 541).

But the practice of medicine, and to only a slightly less extent the sale of doctors' services even upon a prepaid plan, is separated into forty-eight territorial compartments.

B. Medical Societies Have the Right to Adopt Reasonable Measures to Regulate Fair Dealings Among Their Members and Maintain and Advance the Standards of Medical Practice

Herein lies an important difference between our case and the *American Medical* case, (C.A., D.C.) 110 Fed. (2d) 703 (1st Appeal), 130 Fed. (2) 233 (2d Appeal), Aff'd. 317 U.S. 519, as well as the English case, which seems to have suggested the prosecution in *American Medical* case, *Pratt vs. British Medical Association* (1919), 1 KB 244. The latter case is quoted at some

length in the first of the two Circuit Court of Appeals opinions in the *American Medical* case, 110 Fed. (2d) 703 at 710-11.

In this English case, plaintiffs were on the staff of an organization known as Coventry Provident Dispensary, somewhat similar to Group Health, Inc., involved in the *American Medical* case. They had not only been expelled from the defendant society but other members of the defendant society were forbidden to consult with them, the penalty being expulsion from the society. In the above English case, the Court found liability because, as the opinion stated, the Court was

> " . . . satisfied that the defendants desired to achieve far more than mere protection of their interests. They desired to punish the plaintiffs as a separate end in itself, and they meant to make that punishment bitter to the last degree . . . It is admitted, moreover, that the defendants desired not only to punish but to ruin the plaintiffs. The complete professional ruin of the dispensary doctors was the essence and aim of the boycott scheme, and of the steps taken by the defendants. This aim, in my opinion, was a wrong motive or purpose, and constituted an unjustifiable intention to inflict injury . . . . In my opinion there is, as a matter of law, evidence on which the jury could properly find that the defendants acted with malice. As a judge of fact, I feel compelled, with the deepest reluctance and abiding distress, to come to the conclusion upon the whole material before me, that the plaintiffs have established actual malice against all the defendants" (1919) (1 KB 244, at 278-9).

Contrast the above case with a later case, not in the Kings Bench but in the Court of Appeals, *Thompson v.*

New South Wales Branch of Medical Association, (1924) A.C. 764. There a member was expelled from the Medical Society because of public criticism by him of alienists in the conduct of mental cases. A Jury's verdict for the plantiff for 2,000 pounds was set aside and this decision was affirmed on appeal, the court holding that there was no cause of action. This was true even though the rules of the society provided that no member of the society could consult with or extend professional recognition to such expelled member. On this latter point the court held that the mere existence of such a rule did not give a cause of action the expelled member being required to prove action detrimental to him pursuant to such rule.

And when the *American Medical* case reached this Court, the Court recognized that if the primary objective of defendants had been to "maintain and advance the standards of medical practice" and had defendants "adopted reasonable rules and measures to those ends," defendants would not have been guilty, even though the result of their action would be to injure Group Health. For this Court quoted, with what seems to us to have been manifest approval, a charge by the District Judge to the jury as follows (317 U.S. at 533):

> "If it be true . . . that the District Society, acting only to protect its organization, regulate fair dealing among its members, and maintain and advance the standards of medical practice, adopted reasonable rules and measures to those ends, not calculated to restrain Group Health, there would be no guilt, though the indirect effect may have been to cause some restraint against Group Health."

The District Court at the trial of the *American Medical* case, having before it of course the opinion of the Court of Appeals on the first appeal, also gave the following instructions:

> "I charge you that the defendants have the lawful right, through action taken in their meetings and conferences to formulate and adopt rules of medical ethics for the control and government of themselves and the members of their societies in the practice of their profession, and the support and maintenance of such principles of medical ethics by legitimate persuasion and reasoned argument or by enforcement of Society rules, laws and regulations, without more, would not constitute unreasonable restraints against Group Health Association, its doctors or members." (R. 1501, United States v. Am. Med. Soc.)

And on the second appeal of the *American Medical* case, the Court of Appeals, recognizing the validity of the contention here being made, quoted from *Anderson v. United States*, 171 U.S. 604, at 615-6, 43 L. Ed. 300, as follows (130 Fed. (2d) at 244-5, n. 55):

> " 'Where the subject-matter of the agreement does not directly relate to and act upon and embrace interstate commerce, and where the undisputed facts clearly show that *the purpose of the agreement* was not to regulate, obstruct, or restrain that commerce, but that it was entered into with the object of *properly and fairly regulating the transaction of the business in which the parties to the agreement were engaged*, such agreement will be upheld as not within the statute, where it can be seen that the character and terms of the agreement are well calculated to attain the purpose for which it was formed, and where *the effect of its formation and enforcement upon interstate trade or commerce is, in any event, but indirect and incidental, and not its purpose or object.*' " (Italics added.)

Government counsel do not seem to dispute the above, for they state that it "is not the conduct of disciplinary proceedings *per se*" that is condemned, but rather their use as "a means of accomplishing an illegal objective" (Br. 117). The objective, as we shall show in the next subdivision of this brief, is not illegal.

In the first appeal in the *American Medical* case the Court of Appeals called attention to several state court decisions relied upon by the defendants, sustaining defendants' contention that disciplinary action by a medical society pursuant to its canons of ethics does not involve any actionable wrong. The court said that, with the exception of two of those cases, "none is apposite" (110 Fed. (2d) at 712). But an examination of those state court decisions makes it abundantly clear that the reason they were not apposite was because the *American Medical case* involved disciplinary action plus certain coercive action, with the primary intent, not to uphold the standards of the medical society, but to punish and injure third parties. Those cases do become apposite, however, if the evidence shows that the sole purpose of the society's action is to maintain its standards of professional conduct—such as insuring noninterference with the doctor-patient relationship. See, for instance, *Harris v. Thomas*, Tex. Civ. App., 217 SW 1068 at 1076-7.

C. The Right of "Legitimate Persuasion and Reasoned Argument"

The complaint in the present case seems to have been framed, as was the indictment in the *American Medical* case, on the theory that defendants by threats and co-

ercion have restrained trade and commerce. This theme received elaboration in plaintiff's More Definite Statement. In that statement are listed some 150 names of doctors who, plaintiff then contended, "have been deprived of an opportunity to practice medicine in Oregon on terms of their own choosing" because of "specific coercion, compulsion, harrassment, threats or pressure designed to induce or compel them to conform to restrictions upon the practice of medicine agreed upon by defendants as a part of, and to effectuate, the conspiracy herein," (R. 63-7). We note that those named included several whom government counsel later claimed were among the conspirators—among those coercing, not those being coerced. These include defendant Dr. Hunt, Dr. Leslie S. Kent, President of the State Society when the suit was instituted, former presidents James G. Hayes, Thompson Coberth, Thomas A. Griffith and several of defendants' witnesses.

Near the conclusion of the trial, Appellant amended this portion of the More Definite Statement, by eliminating reference to coercion, harrassment, etc.—thus emphasizing what already was apparent, that they had abandoned their theory of coercion (R. 82).

Now their contention apparently is that coercion is not a necessary element in the cause of suit.

Their contention now seems to be that the conspiracy consisted of the adoption of resolutions, the formulation of policies, urging doctors to do certain things, and like conduct—all far short of coercion or harrassment. This surprising contention will be discussed despite the

fact that, as we have shown, the evidence proves that noncooperation of doctors with hospital associations (to the extent it exists) has for many years been the action of individual doctors, uninfluenced by medical societies.

Apparently counsel believe that those great rights guaranteed by the First Amendment of the federal Constitution were not intended to extend to doctors.

Counsel seem to ignore some of the great decisions of this Court outlining the extent of the rights preserved by that amendment. In one of them, *Thomas v. Collins,* 323 U.S. 516, 531, the late Mr. Justice Rutledge made it clear that

> " . . . the rights of free speech and a free press are not confined to any field of human interest."

And since counsel insist that doctors, when selling their services on a prepayment plan, are engaged in business activity, we quote further from that opinion:

> "The idea is not sound, therefore, that the First Amendment's safeguards are wholly inapplicable to business or economic activity. And it does not resolve where the line shall be drawn in a particular case merely to urge, as Texas does, that an organization for which the rights of free speech and free assembly are claimed is one 'engaged in business activities' or that the individual who leads it in exercising those rights receives compensation for doing so."

In the above case of *Thomas v. Collins,* 323 U.S. 516, the Court held that Texas could not place even slight or formal obstacles to the right of a labor union to persuade workmen to affiliate with it. The First Amendment also prevents Congress from telling employers' groups that

they cannot use persuasion upon employees to induce them not to join unions, so long as coercion is not added to the persuasion. *National Labor Relations Board v. Virginia Electric & P. Co.*, 314 U.S. 469; *Nationol Labor Relations Board v. Ford Motor Co.*, 114 Fed. (2d) 905.

It prevents legislative action to "make it a crime publicly or privately to speak, urging persons to follow or reject any school of medical thought." (Jackson, J., concurring, *Thomas v. Collins*, supra, 323 U.S. at 544.)

The right of free speech is protected even though it "stirs the public to anger, invites dispute, brings about a condition of unrest, or creates a disturbance." *Terminiello v. Chicago*, 337 U.S. 1.

Until recently, this right of free speech protected members of the Communist Party in advocating the overthrow of the government of the United States by force and violence. To hold the preaching of such gospel to be criminal, it was necessary for Judge Medina, Judge Learned Hand and his associates and later for this Court to find a "clear and present danger." *United States v. Dennis*, 183 Fed. (2d) 201; Aff'd. *Dennis v. United States*, 341 U.S. 494.

The guaranties of the First Amendment likewise prevent legislative action against picketing by labor organizations, under some circumstances, to enforce their demands. *Thornhill v. Alabama*, 310 U.S. 88, 84 L. Ed. 1094; *Carlson v. California*, 310 U.S. 106, 84 L. Ed. 1104. And even when picketing may be prevented, other forms of free speech may not. Thus while a state may prevent

picketing to enforce a demand upon a self-employer to compel a union shop, "all other channels of communication," i.e., all other aspects of freedom of speech to achieve their objective, are reserved to the unions. *International Brotherhood v. Hanke,* 339 U.S. 470, 477.

Coming back to the subject immediately at hand, we quote again from Mr. Justice Rutledge's opinion in *Thomas v. Collins,* supra, 323 U.S. at 537:

> " 'Free trade in ideas' means free trade in the opportunity to persuade to action, not merely to describe facts."

Of course the *American Medican Association* case, (C.A., D.C.) 110 Fed. (2) 703 (1st Appeal), 130 Fed. (2d) 233, Aff'd. 317 U.S. 519, instead of teaching anything inconsistent with the above doctrines, reaffirms them. Counsel do not cite that case in support of their position—implicit throughout their brief—that doctors do not have the right to preach to other doctors and to the public what they conceive to be the dangers of a system of medical service brokerage which inevitably results in laymen telling doctors how to treat patients. They cite no authority for that position whatever.

For the *American Medical Association* case makes it clear that it is *coercion* that is outlawed, that the right to "legitimate persuasion and reasoned argument" is left open to the medical profession.

The decision in the *American Medical* case did not hold, as counsel seem to assume, that the objective of the defendant associations was invalid; it was only the

means used to achieve that objective that were condemned. Thus, in the first of the Court of Appeals opinions, 110 Fed. (2) at 711, the Court first quotes from the English decision in *Pratt v. British Medical Association,* supra, that the opinion of the court "leaves them with the safer and more kindly weapons of legitimate persuasion and reasoned argument." In agreement with this position, the court then says (110 Fed. (2) at 712):

> "If on the trial the charge of confederation to this end is sustained, defendants' *method* of reaching their objective may be therby defeated, but if the objective is wise—as they insist—*they still have left,* as was said by the English judge in the Pratt case, *the safer and more kindly weapons of legitimate persuasion and reasoned argument.*" (Italics added.)

Again, on the second appeal, the Court of Appeals made its position on this point clear. Analogy was drawn between the medical profession and the legal profession, the court pointing out the great changes which have taken place in recent decades in the lawyers' professional work. "There are some," said the court, 130 Fed. (2) at 245-6, "who regret and some who resent these changes. Over the years, as individuals and as members of professional associations, they have labored to prevent or minimize them. But they would not suggest that criminal conduct, as individuals or as associations, would be proper for such a purpose."

The court also points out, page 248, that the American Bar Association attempted by certain lawful methods to prevent activities "which they regarded as en-

croachments upon the practice of law. These methods, the court said, "are equally available to appellants" and particularly

> " . . . As we suggested in our earlier opinion, appellants have open to them always the safer and more kindly weapons of legitimate persuasion and reasoned argument, as a means of preserving professional esprit de corps, winning public sentiment to their point of view or securing legislation."

Of course between the time the two above opinions were given by the Court of Appeals, a trial was had in the District Court. We commend to the Court's consideration the rules laid down by Associate Justice Proctor in his charge to the jury. Explaining to the jury that defendants could not use coercive methods to attain their objectives he pointed out that they did have the right through concerted action by "legitimate persuasions and reasoned argument," orally and through articles in the press, including publications of medical societies, to endeavor to have their methods of practicing medicine prevail. Quotations from this charge are set forth in Appendix E.

One of the landmarks in delineating the means by which legitimate objectives may not be accomplished is the series of cases involving attempts by automobile manufacturers to compel the use by dealers of their subsidiary finance corporations. The first of these is *United States v. General Motors Corporation,* (C.A. 7) 121 F. 2d 376.

But that case is important, not only in holding that the General Motors organization could not coerce dealers

into using GMAC financing, but also in holding that they could use persuasion and argument to endeavor to accomplish the same end. The pertinent portion of the trial court's instructions in the *General Motors* case will be found in the later companion case of *Ford Motor Company v. United States,* 335 U.S. 303, 316, footnote 3. There the court held that the aim of the General Motors Corporation could be achieved, if possible, through "exposition, persuasion, argument," but they were not entitled to use coercion.

The court instructed the jury:

> "Persuasion means something softer than argument, perhaps, but he may argue with him, and argue with him the respective merits of his product and other products being offered to the person to whom he makes his offer.
>
> "All of these are proper.
>
> "He may not go beyond that and use something that is within his power to use as a club to coerce the person to accept that which he has to offer."

During the past thirty years or more, it has repeatedly been impressed upon us by the opinions from this Court that the limit of the doctrine of free speech is determined by the "clear and present danger" test. We have perhaps taken too much space in this brief elaborating the thought that the test is not whether it affects interstate commerce. That our chambers of commerce have the right to urge people to "buy Oregon," that our housewives have the right collectively to refuse to buy meat until the price goes down, that members of church organizations have the right to agree that they will refrain from attending indecent moving pictures and urge

others to do likewise (but see Marcus "Anti-Trust Laws and the Right to Know," 24 Ind. L. Journal, 513, 542-6), that the ladies of the W.C.T.U. are within their legal rights in agreeing not to purchase a lawful article of interstate commerce and to urge others to follow a like course—these and countless other instances of propaganda by groups have always seemed to us clearly to fall within the right of free speech.

In presenting the above argument, we hope it will be clearly understood that we are not conceding by implication that the position which numerous doctors in Oregon have taken with regard to commercial hospital associations, since 1941 at least, has been the result of concerted action by the medical societies. But just as earnestly we are insisting that the doctors of Oregon, and elsewhere, do have the right to adopt policies believed by them to be in the public interest and to endeavor to secure acceptance of those policies by others through any legitimate means.

D. Defendants' Actions for the Purpose of Protecting Interest of Themselves and of the Public

In the present case it is clear from the evidence, as the trial court expressly found (R. 2022-3), that there is no concerted refusal by doctors to deal with commercial hospital associations. In view of the overwhelming evidence supporting this finding, it should not be necessary to discuss at great length the legal justification for what defendants did, or more accurately what the government claims they did. However, we point out that even if

there were a concerted action on the part of Oregon doctors not to deal with commercial hospital associations, that conduct, even aside from the professional ethics involved, has ample legal justification.

One of the cases cited on this point in the brief (p. 126), *Eastern Retail Lumber Dealers' Association v. United States,* 234 U.S. 600, is a good illustration of the limited scope of the rule for which appellant contends. There several associations of retail lumber dealers agreed that if a wholesale lumber dealer engaged in retail trade in competition with the members of any one of these associations, the members of all associations would refuse to deal with him. The court held this agreement to be an unlawful restraint of trade; but made it clear that there is no such broad rule of law as that laid down in appellant's brief.

The reason why the agreement in the above case was illegal, as pointed out by the court (234 U.S. at p. 612) was that under such an agreement many retailers who agreed not to deal with the offending wholesaler were in no way affected by the offence—they all agreed to boycott the wholesaler "because of the grievance of a member of one of the associations,". Had the agreement not to deal with a wholesaler been restricted to those affected by the wholesaler's conduct, the agreement would clearly have been valid.

That this is so is set forth in the Restatement of Torts, Sec. 765, Illus. 6.

The Restatement, Sec. 765, sets forth the many considerations involved in determining whether a refusal to do business with a party is a valid or invalid restraint of trade. Among the important factors are "the objects sought to be accomplished and the interests sought to be advanced by the actors' conduct;". And as pointed out in the illustrations, pages 46-8, either self-interest or the public interest suffices to save combined refusal to trade or deal from being an illegal restraint. On page 45, the authors say:

> "But self-interest, particularly a purpose to advance the business interest of the actors, may be a justification even though the harm caused by the refusal is intended to be the means of advancing that interest."

To the same effect, see Learned Hand's opinions in *Fashion Originator's Guild v. Federal Trade Commission,* (C.A. 2) 114 Fed. (2d) 80, at 84, and in *United States v. United Press* (S.C., N.Y.) 52 Fed. Supp. 362, at 368-71; Harper on Torts, Sec. 234; Prosser on Torts, Sec. 105.

The present case in this respect as well as in many others is in sharp contrast with the *American Medical* case. The Court of Appeals on the first appeal was careful to point out (110 Fed. (2d) at 713) that there, as in the *Eastern States* case, the conduct of group health did not affect that portion of the medical profession represented by defendants—they had no "personal grievance." It also contrasted (p. 714) the non-profit organization there involved with commercial hospital associations such as we have here.

In fact, the difference in this respect between the present case and the *American Medical* case is even greater. For the typical example of a personal interest which justifies conduct, otherwise invalid, is, as the above authorities point out, the interest of a competitor.

On the general subject of the significance of competition as a justification for acts which otherwise would constitute an illegal restraint of trade, see Restatement of Torts, Secs. 767, 768; Prosser on Torts, Sec. 105, pp. 1020-9.

Plaintiff's brief points out, and emphasizes, the control which the State Medical Society has over the conduct of Oregon Physicians Service (p. 19). This competition, as plaintiff's brief complains, has consisted in urging doctors not to work for their competitor. Even though all the contentions of plaintiff with respect to defendants' conduct were true, it would be nothing more or less than the methods traditionally followed by competitors ever since a merchant first endeavored to induce the public to trade with him instead of his competitor.

There is another aspect of the element of competition that is important. The very purpose of the Sherman Act is to promote competition. As pointed out by the Court of Appeals in the second appeal in the *American Medical* case, the very purpose of the societies in Washington, D.C., in carrying on their coercive conduct, was to *prevent* "the bitterest kind of competition in making available medical and hospital service" (130 Fed. (2d) 241). In the present case, in portions of Oregon since 1930, and throughout the entire state since 1941, the doc-

tors of Oregon, through their medical societies, have been in open and active competition with commercial hospital associations.

In most of the instances dealt with in the above authorities, self-interest of the parties to the agreement or other conduct was held sufficient to justify the agreement or conduct. But when to this is added the public interest, the agreement is clearly valid.

A good illustration of the latter (where an agreement refusing to deal is upheld because of both self-interest and public interest) is *Appalachian Coals, Inc., v. United States,* 288 U.S. 344, There an agreement among the producers of bituminous coal appointing a single sales agent for all of them, the agent being a corporation in which the parties to the agreement owned all the capital stock, was held valid. The agreement was both in the interest of the parties and in the public interest.

The evidence is clear, as we have pointed out, that when this alleged conspiracy is said to have commenced as well as when Oregon Physicians Service was organized a situation had arisen which was threatening, to use the expression of the Supreme Court of South Dakota, the degradation and debasement of the medical profession. *Barton v. Coddington Company,* 68 S.D. 309, 2 N.W. (2d) 337, 344-6, 140 A.L.R. 550, 561-3.

Certainly here there was not only self-interest of the doctors but also the public interest, in counteracting these degrading and debasing influences.

E. There Is No Threat of Monopoly

In view of the impelling motives which have actuated defendants of protecting the standards of medical practice and of furthering the public interest, there would seem to be no force in the government's contention that they are endeavoring to monopolize the prepaid medical care business in the State of Oregon (Complaint, par. 31(a); R. 6).

But there are two further answers to this charge of monopolization.

(1) The evidence is clear not only that Oregon doctors do not wish their organization, Oregon Physicians Service, to have a monopoly on the sale of prepaid medical care (R. 1113, 1299, 1362, 1477), but also that since this supposed conspiracy is claimed to have started the business of commercial organizations in selling prepaid medical care has increased several fold (Ex. 1262, 1267; R. 4810, 4866). And the trial court accordingly has found that the conduct of defendants does not tend to promote a monopoly (R. 2021, 2025-6).

By what we say above, we do not mean to suggest that there are not many doctors who believe it would be in the public interest if the sale of doctors' services were exclusively under the control of the doctors themselves.

(2) The doctors of Oregon have a monopoly in that State given them by statute in the *furnishing* of medical and surgical services; and it hardly seems that if through competition they should obtain a "monopoly" in the *sale* of those same services, they would be in violation of the

Sherman Act. For, as Judge Learned Hand said in *United States v. Associated Press,* (S.C., N.Y.) 52 F. Supp. 362, 374:

> "A monopoly of all those interested in an activity is no monopoly at all, for no one is excluded, and the essence of monopoly is exclusion . . . If other services were incidentally driven out, that would not be an actionable wrong."

The above quotation is set forth in one of the trial judge's notes (R. 2013).

F. The Public Interest Is Paramount

The representatives of the United State government charged with the protection of the public interest strangely seemed less concerned with the furtherance of that interest than with assuring to commercial hospital associations even larger profits from their brokerage of doctors' services than those tremendous gains they have heretofore enjoyed. The public interest seems not to have been considered by them. In short, there is an entire abandonment of the position taken by their predecessors in the *American Medical* case. See Appendix F.

But, plaintiff's contentions to the contrary notwithstanding, in anti-trust proceedings, as in other injunction suits brought by public authority, the public interest comes first. This has clearly been established since *Standard Oil Company v. United States,* 221 U.S. 1, reaffirmed in *United States v. American Tobacco Company,* 221 U.S. 106. In the last cited case the court said, 221 U.S. at 179:

> "Applying the rule of reason to the construction of the statute, it was held in the Standard Oil Case that as the words 'restraint of trade' at common law and in the law of this country at the time of the adoption of the Anti-Trust Act only embraced acts or contracts or agreements or combinations which operated to the prejudice of the public interests by unduly restricting competition or unduly obstructing the due course of trade or which, either because of their inherent nature or effect or because of the evident purpose of the acts, etc., injuriously restrained trade, that the words as used in the statute were designed to have and did have but a like significance."

Recently in *Standard Oil Company v. United States,* 337 U.S. 293, some of the members of this Court, in the minority, thought that the same rule of reason should apply to Sec. 3 of the Clayton Act (15 (U.S.C.A., Sec. 14); but the majority because of different language in that Act thought otherwise. The court's opinion, however, was clear that in the enforcement of the Sherman Act, the questions involved include the "tests of detriment to the public interest" (337 U.S. at 312-3).

To the same effect is *Board of Trade v. United States,* 246 U.S. 231, 238.

In the *American Medical Association* case, on the first appeal, 110 Fed. (2d) 703, at 711, the court quoted with approval from the English case of *Pratt v. British Medical Association,* (1919) 1 K.B. 244 at 274, as follows:

> "The public interest must be regarded conjointly with the interests of individuals when restraint of trade is in question."

The facts in the *American Medical* case, differing from the facts here, were such that the public interest was served by preventing the actions of defendants. There, there was no brokering of doctors' services, without their consent. No layman had the right to interfere in the doctor-patient relationship. It was an association of prospective patients who employed their own doctors. The court on the first appeal (110 Fed. (2d) at 713), found it desirable "at the risk of tedious repetition" to emphasize that the charge before the court was that the societies "sought to restrain an association of persons of modest means from receiving medical services at lower cost and to coerce doctors and hospitals to this end." But here, doctors have themselves promoted a system whereby what was restrained in the *American Medical* case is here promoted—an opportunity for persons of modest means to procure medical services at low cost. And in so doing, the doctors of Oregon have freed their profession from the degrading and debasing influences that formerly prevailed.

There is no question on which side the public interest lies.

V. EFFECT OF THE TRIAL COURT'S FINDINGS

The Court made fifty findings of fact (R. 2017-44), of which the first eighteen merely adopted undisputed allegations of the complaint. Of the remainder, appellant now "is seeking to overturn, in whole or in part, 20 of them" (Br. 101).

In Appendix A we have rearranged the findings under appropriate headings and to some extent summarized them.

We would not be true to our obligations either to the Trial Court or to this Court if we did not answer the charge in the government's brief (p. 104) that the record indicates that the findings were " 'mechanically adopted' with but one slight change from those proposed by appellees," and that they result from a "notion . . . not resting on any judicial evaluation of the evidence . . . "

No member of the Bench and Bar acquainted with the painstaking care and the conscientious, enlightened attention to detail that has characterized Judge McColloch's judicial career, will believe any such charge nor fail to be shocked that members of the bar should so speak of him.

As we shall presently show, other than findings on uncontroverted issues, it was the directions of the court which were "mechanically adopted," not proposals of counsel.

So we wish to set forth what the record actually discloses.

In the Oregon District because of the extensive use of the pretrial procedure the court and all the parties rather well know what the cases are all about before trials actually start. As disclosed by transcripts of those proceedings (not printed), many such pretrial conferences were held in this case. In accordance with the Oregon practice, most of the exhibits, with pretrial numbers

affixed, were tendered into court prior to the commencement of the trial. These exhibits received the careful attention of the trial judge and on October 11, 1949, he stated in open court to government counsel that " . . . it seems to me, after going through *a thousand or more documents that I have already seen,* that your theory of the case is covered very well by documentary matter." (Tr. of proceedings, October 11, 1949, not printed. Italics added.)

Notwithstanding such familiarity gained by the court in these pretrial proceedings, prior to the taking of testimony the parties made lengthy opening statements (Pltf's, R. 326-30; Def's, R. 330-50).

During the time that the government was introducing its evidence, the court notified the parties to be prepared at the conclusion of the government's case to fully present their respective theories (R. 819).

After the government had rested and on November 10, 1949, defendants filed a motion to dismiss. The legal theories of the parties and their appraisal of the evidence were forcefully and at great length presented. (Government, R. 931-5, 976-85; Def's, R. 935-75, 985-9). As appears from the record, the Court dozens of times interrupted counsel to ask questions, evincing a keen grasp of the issues involved and a penetrating "judicial evaluation of the evidence."

After both sides had rested, government counsel prepared and filed a 516 page printed brief which the court had for two months before the opinion was given.

In addition to stating his views on facts in that opinion and also in some accompanying notes, the learned trial Judge set forth fourteen findings or directions, to be used by counsel in the preparation of formal findings of fact. Of course at that time neither side had tendered any proposed findings.

A comparison of those directions for the entry of findings (R. 2006-9) and the twenty formal findings which the government specifically challenges (Br. 101) discloses a remarkable similarity.

This is particularly true of those findings which are the crux of the case, those which counsel set forth at length in the brief followed by an attempt to discredit them. Thus, compare the findings set forth on page 51 of the brief with the Trial Judge's directed findings at R. 2009, Nos. 3058 and 3059; page 69 of the brief with R. 2007, No. 3050 and R. 2009, No. 3060; page 83 of the brief with R. 2009-10, No. 3065.

In fact—and we are certain that present counsel for the government must have overlooked this in making the charge that the trial judge "mechanically adopted" counsel's proposed findings—so thoroughly did the trial judge in that opinion cover the ground that three weeks later Acting Assistant Attorney General Underhill wrote a letter to the trial judge in which he said (R. 2045):

> "Since almost all the findings we would want to propose would conflict with your Honor's decision and findings made therein, we have decided that we will refrain from submitting formal proposed findings, except a few relating to membership in the defendant medical societies."

The particular object of counsel's attack appears to be the trial judge's reference to "socialized medicine" (Br. 8-9, n. 4, 104-5). This was not part of the opinion itself, but was contained in "notes" on a variety of indirectly related subjects. We know of no reason why if a trial judge, by "reading between the lines" (see, e.g., R. 1443, 1446) or getting a "feel" of the atmosphere of the trial, detects a fear by doctors that the case may involve a threat of socialized medicine, he should hesitate to say so.

The principal contention of the government with respect to the support of the findings by evidence is not that there is not an abundance thereof, but that such evidence is contradicted by written records—resolutions, letters, articles in *Northwest Medicine*, etc. We have commented on the unreliability of documents of that kind as a basis for indicting hundreds of members of a voluntary, unincorporated association, many of whom were admitted years after the documents were written and most of whom, even though members at the time, never heard of them (supra, 35-8). A somewhat similar situation, as we there indicated, was before the Court in *United States v. National Association of Real Estate Boards*, 339 U.S. 485, where government counsel made a similar argument with respect to the realtors' code of ethics. The argument was rejected. The Court said:

> "It is not enough that we might give the facts another construction, resolve the ambiguities differently, and find a more sinister cast to actions which the District Court apparently deemed innocent. See United States v. Yellow Cab Co., 338 U.S. 338, 342,

ante, 150, 153, 70 S.Ct. 177; United States v. United State Gypsum Co., 333 U.S. 364, 394, 395, 92 L. Ed. 746, 765, 766, 68 S.Ct. 525. We are not given those choices, because our mandate is not to set aside findings of fact 'unless clearly erroneous' " (339 U.S. 485, 495-6).

The experienced and able Trial Judge who tried this case has had a lifetime of legal practice and judicial experience throughout th .i Oregon and his findings of fact are not to be r .d on any basis suggested by counsel. The .portunity of the trial judge to observe the witnesses, to determine which were to be believed, to observe which might be governed by animosity toward doctors or by other considerations, which appeared to be frank and honest, is peculiarly important in a case such as this.

It is, indeed, a case in which the rule is particularly appropriate that findings of fact "shall not be set aside unless clearly erroneous, and due regard shall be given to the opportunity of the trial court to judge of the credibility of the witnesses."

CONCLUSION

The right of the members of the medical profession to voice their opposition to practices which have threatened to debase their profession is at stake in this case. If doctors are right in their insistence that they should be permitted to treat their patients "as private patients" with a devotion undiluted by an enforced feeling of obligation to a corporate cash register in the distance, then this case should be affirmed.

Respectfully submitted,

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December 24, 1951

APPENDIX A

Summary of Findings

(The following is intended as a summary of what we consider to be the important Findings and Conclusions of the Trial Court, segregated under appropriate topics. In some cases Findings, or portions of them, are set forth verbatim, in other cases summarized. No attempt has been made to indicate by quotation marks those portions in which the Court's language is used. As used in these Findings, as in the brief itself, the expressions "commercial prepaid medical care organizations" and "hospital associations" are used interchangeably and mean the same thing.)

1. Interstate Commerce.

In view of other Findings and Conclusions, the Court finds it unnecessary to determine whether interstate commerce is involved in the practice of medicine, in prepaid medical care sales, or other acts of defendants (Conclusion IV, R. 2030).

Among the various organizations engaged in paying for or supplying medical care in Oregon on a contract basis (No. 12, R. 2019), only one has an office outside the State of Oregon, it having one office in Portland, Oregon, and one in Vancouver, Washington, across the Columbia River. This organization is a partnership of seventeen doctors, some residing in Portland and some in Vancouver, Washington, caring for patients in both states (No. 13, R. 2019).

The Court, however, takes judicial notice that many insurance companies incorporated in other states sell insurance policies in Oregon, as elsewhere, providing indemnity against expenses for doctors' bills (No. 13, R. 2019). These companies have a large volume of business. Their manner of operations has had the approval of defendants throughout the period involved in this suit and no attempt has been made to prove any restraint by defendants of that type of business (No. 35, R. 2025).

Use of interstate transmission facilities

Organizations with offices in Oregon engaged in the sale of prepaid medical care have sold policies in that State and also in Washington and California. In so doing they have transmitted their policies, reports, instructions and correspondence across state lines. Such contracts include reimbursement for medical care obtained by Oregon residents while in other states (No. 14, R. 2019-20). These organizations, for the purpose of furnishing first aid supplies to certain industries, have purchased and procured medicines, drugs and supplies and instruments from other states (No. 15, R. 2020).

Some industrial concerns having employees in Oregon and also in other states have prepaid medical care agreements covering their employees both in Oregon and other states (No. 16, R. 2020).

Oregon doctors sometimes treat patients who come here from other states for such treatment, some of whom are policyholders in Oregon prepaid medical care organizations. These nonresidents also sometimes use facilities of Oregon hospitals. Conversely, sometimes doctors in

other states treat residents of Oregon who are also sometimes patients in hospitals in other states (No. 17, R. 2020).

Medicine, drugs, medical supplies and equipment come into Oregon to be used by doctors and hospitals (No. 18, R. 2020).

Practice of medicine not commerce

Neither the practice of medicine as conducted in Oregon, nor the sale of medical services by doctor-sponsored organizations as conducted in Oregon is trade or commerce within the meaning of sec. 1 of the Sherman Anti-Trust Law, nor commerce within the meaning of the constitutional grant of power to Congress "to regulate commerce among the several states" (No. 41-2, R. 2026).

2. General Findings.

Defendants are not guilty of any of the charges set forth in the complaint (Conclusion III, R. 2030). None of them at any time has attempted to, or been engaged in any combination or conspiracy to, restrain or monopolize the business of selling or furnishing prepaid medical care in the State of Oregon or otherwise, or to restrain or monopolize interstate trade or commerce in said business nor do any of the defendants threaten or intend to do so (No. 20, R. 2021).

The motive and intent of defendants has not been to restrain or monopolize, and monopoly has not in fact resulted and does not exist, nor does any unreasonable restraint exist in the business of prepaid medical care (No. 37, R. 2025-6).

3. Medical Societies in Oregon.

Each of the defendant medical societies is a voluntary unincorporated association. The defendants Oregon State Medical Society and Multnomah County Medical Society each has an office and place of business in Portland, Oregon. None of the other defendant medical societies has any office or place of business. Each of the defendant county medical societies is to a limited extent affiliated with defendant Oregon State Medical Society (Nos. 1, 3, R. 2017-8; No. 34, R. 2025).

Membership or nonmembership in any of defendant societies has no effect on the privilege to practice medicine in Oregon under state laws (No. 34, R. 2025).

At no time within recent years has the membership in any medical society been denied to any doctor because of his connection with any private hospital association (No. 49, R. 2029).

The number of physicians and surgeons in Oregon licensed to practice and also the number of members of the State Medical Society, during each of the years from 1936 to 1940, both inclusive, are set forth in Finding 50 (R. 2029). As shown therein in 1936 there were 1215 licensed to practice of whom 742 were members of the State Society, and in 1948 there were 1660 licensed to practice of whom 1210 were members of the State Society (No. 50, R. 2029).

In the following counties practically all the doctors are members of their local societies: Columbia, Clackamas, Douglas, Jackson, Marion and Polk. In 1949 de-

fendant Multnomah County Medical Society had at least 600 members (No. 51, R. 2029).

4. Oregon Hospitals.

Membership on the hospital staff of general hospitals in Oregon is granted or withheld by the governing body of each hospital. Such membership has not been granted or withheld from any doctor because of his connection with any prepaid medical care organization, whether such organization was sponsored by defendants or not (No. 34, R. 2025).

While the complaint alleged a restraint on hospitals by defendants, no substantial evidence was offered in support thereof and the Court finds that none of the defendants has in any manner restrained hospitals or hospital services or the opportunities of doctors or of patients to obtain hospital services (No. 48, R. 2028-9).

5. Improper Practices of Hospital Associations.

In the earlier portion of the time involved in this suit, hospital associations engaged in many practices which interfered with the doctor-patient relationship in Oregon and were not for the best interests of the doctors' patients. Because of these practices, they alienated individual doctors, some of whom still hold animosity against such associations. But with the evolution of the hospital association business, and the gradual tendency to eliminate abuses, and the coming of new doctors on the scene, the past is gradually becoming forgotten (No. 36, R. 2025).

6. Defendants' Actions with Respect to Commercial Hospital Associations.

No conspiracy by defendants

There has been no conspiracy, agreement, combination or concert of action among defendants either (a) to monopolize prepaid medical care business either in Oregon or any other state, or (b) to limit the scope of medical care provided by prepaid medical care plans, or (c) to prevent, hinder or obstruct any commercial organizations from engaging in such business, or (d) to restrain any persons from obtaining prepaid medical care agreements with organizations not sponsored or supported by defendants, or (e) to prevent doctors from cooperating with such prepaid medical care organizations, or (f) to restrict the use of hospital facilities by doctors cooperating with commercial organizations, or (g) to prevent hospitals from allowing their facilities to be used by doctors or by patients associated with such organizations (No. 21, R. 2021).

No unlawful conduct by any defendant

None of the defendants at any time has ever either individually or by combination or conspiracy with others (a) interfered with such commercial organizations in obtaining hospital facilities for their members (No. 25, R. 2022) nor (b) refused to treat patients or caused others to refuse to treat patients or in any way discriminated against such patients by reason of any such membership (No. 26), nor (c) refused or encouraged others to refuse to give patients itemized statements to enable them to be

reimbursed under prepaid medical plans (No. 27, R. 2023), nor (d) refused to consult with or assist, or encouraged others not to consult with or assist, doctors who treat members of prepaid plans (No. 28), nor (e) spread any false propaganda for the purpose of discrediting such medical care plans (No. 29), nor (f) attempted to make hospital facilities available only to members of the medical societies or restricted or excluded qualified doctors from the use of hospital facilities (No. 31, R. 2024).

Defendants' conduct prior to 1941 not conspiracy.

Prior to 1941, some of the defendants advised doctors not to cooperate with commercial prepaid care organizations in certain practices engaged in by them (No. 22, R. 2021-2). Also, prior to 1941 defendant Multnomah County Medical Society (but no other defendant) expelled certain members engaged in certain types of contract practice and threatened the expulsion of other members so engaged (No. 23, R. 2022). No such action either in so advising doctors or in expelling doctors was the result of any combination, agreement or conspiracy and in every case was for the purpose of maintaining the standards of medical practice among the members of the medical societies (No. 22-3, R. 2022).

No doctor has been expelled or threatened with expulsion from any medical society since 1941 because of any cooperation by him with a commercial medical care plan (No. 23, R. 2022).

Change of situation in 1941.

Although the Court finds that there was no conspiracy at any time, nevertheless, if there was one prior to 1941 "the thread was broken and the conspiracy ended" when a large percentage of doctors entered the armed forces, and when the doctors "reversed their position in 1941" and themselves engaged in contract practice through the medium of Oregon Physicians Service, thereby becoming competitors of privately owned and operated medical care organizations (No. 38-9, R. 2026). If some or all defendants at any time boycotted privately owned hospital associations, none of them has done so in recent times or has any intention to do so in the future (No. 47, R. 2028).

Defendants have not brought about results charged

Nothing done by any of the defendants has prevented or hindered prepaid medical care organizations in entering into or expanding their business in Oregon, or other states, except that defendants have lawfully competed with commercial prepaid medical care organizations (No. 32, R. 2024). Specifically, no act of the defendants has (a) deprived anybody of the opportunity to acquire prepaid medical care insurance from organizations competing with one another in a free market, nor (b) deprived any person of medical care, nor (c) adversely affected business concerns in obtaining prepaid medical care for their employees in an unrestrained market, nor (d) deprived doctors of the opportunity to practice medicine on terms of their own choosing, nor (e) caused doctors to be denied the use of hospital facilities, nor (f) caused

hospitals to be prevented from making their facilities available to doctors or members of the public; nor (g) caused the market for the sale and distribution of medicines, drugs, medicine supplies or medical equipment to be restricted (No. 33, R. 2024).

No conspiracy not to "take tickets"

When a doctor who renders services to a member of a prepaid medical care plan sends his statement for services to the organization controlling it and accepts such organization's check in payment for his services, he is said to "take tickets" of that organization. Commercial hospital associations have not requested that doctors "take tickets." The contracts of such commercial associations do not obligate them to make payment to doctors who send them their statements for services to patients. There is no conspiracy, combination, agreement or concert of action among doctors not to "take tickets" of privately owned hospital associations (No. 46, R. 2028).

7. Organization and Conduct of Prepaid Medical Care Organizations Sponsored, Owned or Controlled by Defendant Medical Societies.

In the formation and promotion of their own prepaid medical care plans, defendants have not acted pursuant to any conspiracy, combination or attempt to restrain or monopolize or to drive out, hinder or obstruct commercial prepaid medical care plans but to compete with them. Such commercial plans have not been driven from the state nor hindered or obstructed except as they may

have been affected by legitimate competition of defendants' plans (No. 24, R. 2022). The statewide plan, Oregon Physicians' Service, was organized in 1941 (No. 39, R. 2026). It was intended to be and has been an agency to provide prepaid medical care by doctors (a) in areas where prepaid medical care was not being offered by local doctors and (b) in cases where groups of patients lived or worked in more than one county. It provides medical and hospital care in one form or another on a prepaid basis in every county in Oregon. Most of the doctors participating in local doctor-sponsored plans also are participating physicians in Oregon Physicians Service (No. 30, R. 2023).

Non-competition between doctor-sponsored plans.

There has been no attempt on the part of Oregon Physicians Service to sell prepaid medical care in any county in the state without the consent of the doctors of such county nor any attempt by any local doctor-controlled plan of one county to sell prepaid medical care in other counties of the state. The reasons are (1) that doctors believe that they should not attempt to sell the services of other doctors without the consent of the latter, and (2) that competition in a single county between two such doctor-sponsored plans is impractical, since the same doctors must render services under whatever plans are in operation. These policies are not because of any conspiracy or combination in restraint of trade or commerce and have not resulted in restraining or monopolizing the business of selling or furnishing prepaid medical care (No. 30, R. 2023-4).

Monopoly has been neither purpose nor effect.

The purpose of defendants in forming and promoting prepaid medical care plans was not to attempt to restrain or monopolize trade or commerce nor to drive out or hinder commercial prepaid medical plans but to compete with them (No. 24, R. 2022) and to meet the social need which had arisen for group medical care, without the element of private profit, over and above legitimate hospital and medical charges (No. 45, R. 2027-8). The commercial organizations have not been driven from the State of Oregon, nor hindered or obstructed except as they have been affected by legitimate competition of plans sponsored by defendants (No. 24, R. 2022). Neither monopoly nor any unreasonable restraint exists in the business of prepaid medical care by reason of any act on the part of defendants or any of them (No. 37, R. 2025-6).

8. Fee Fixing by Doctors.

The only fee schedules in the preparation of which any of the defendants have participated have been in connection with (1) activities of government agencies, at the request of such agencies, and (2) prepaid medical care plans of Oregon Physicians Service and other doctor-sponsored prepaid medical care plans. In the case of the latter, the schedules do not themselves necessarily set forth the actual fees to be collected by doctors, but only determine the relative proportions of the net profits of such prepaid plans to be received by doctors for specified services during any given period of time. Such fixing of fees is a necessary element and of the very es-

sence of all prepaid medical care plans. Thus, commercial organizations engaged in this business also fix or designate or determine fees for services to be paid by them either in payment of services or maximum amounts of indemnity for expenses incurred for services (No. 44, R. 2027).

APPENDIX B

Extracts from letters from commercial hospital associations to doctors, prior to 1941, illustrative of interference in doctor-patient relationship, questioning honesty or good faith of doctors, imposing burdensome details upon them and related matters, all written by laymen; also extracts from fee schedule.

Ex. 1873; R. 6736:

> "We note you have made a charge for a fluoroscopic examination of the stomach on February 2nd. We do not find a record of this case having been reported to us and authority obtained for this examination."

Ex. 1874; R. 6737:

> "However, before authorizing the G.I. study we believe it would be well to await the results of the tonsil operation as the infected tonsils may be causing his intestinal disorder."

Ex. 1935; R. 6749:

> "In checking over these statements . . . we find that out of the forty-two patients who consulted you charges were made for complete examinations in twenty of these cases, and in fourteen of them an

additional charge of $2.00 was made for routine office laboratory work.

"Considering the total number of patients who consulted you the number requiring special examination seems to be entirely out of proportion."

Ex. 2501; R. 6757:

"You of course understand that no operation is to be performed at the expense of the Association without permission is first obtained from us."

Ex. 2577 (p. 4); R. 6808-10:

"Your bill for $71.00 indicates that the case did not respond to your treatments as you had expected and you gave many more treatments than were authorized or contemplated . . .

"The question now confronts us as to whether it is right that we should assume all the added expense, or is it fair to expect the doctor to bear part of the loss when a case does not respond to his treatment and runs into a bill much higher than such cases usually do or should cost us.

. . . . . .

"Financial necessity therefore compels us to question bills that run higher than authorized or higher than the usual cost of any particular case."

Ex. 2588; R. 6821:

"No special nurse can be employed on any case for longer than three days without special authority from our office."

Ex. 2595; R. 6832:

"1. All cases requiring major surgery, except in actual emergency, must be reported to the Association for authority before operation is performed.

"2. It will be the policy of the Association to require consultation before authorizing major surgery."

Ex. 2615; R. 6850:

"You are not the only doctor we are dealing with and we believe you will agree that some doctors are not to be trusted."

Ex. 2627; R. 6868-9:

"It has come to my attention that several times recently you boys have performed operations without first taking the matter up with this Association as is required.

. . . . . .

"Exceptions are always made in emergencies if, after investigation, it is shown that the person is eligible to care at the Association's expense. Will you please mention this to the other boys and let us have your cooperation in the future."

Ex. 2638; R. 6876-7:

"The Association will bear the expense of this operation, but since you are familiar with our regulations which require that cases of this kind be reported and authority obtained prior to the time the service is rendered, we request your cooperation in all future cases."

Ex. 2666; R. 6895:

"This service included an X-ray, but the film has not been received at this office. Please send the film in order that your account may have our attention."

Ex. 2684; R. 6948 (Page 1. Letter to Medford, Oregon, doctor):

"It will be necessary for her to report back to Portland or to her physician at Eugene if she requires further attention as we do not care to authorize any other form of treatment outside of Eugene or Portland."

R. 6949 (Page 3. Letter to Medford employer):

"Our experience has demonstrated to us that when we get too large a staff of doctors it is impossible to give the amount of service we are endeavoring to furnish for the fees charged."

R. 6950 (Page 4):

"We will be responsible for the expense of treatments only when they have been authorized by this office."

Ex. 2686; R. 6953 (March 12, 1935):

"The fees paid by the Association in the Astoria district are as follows:

First office or hospital visit	$2.00
Subsequent visits	1.00
Residence visits	2.00
Mileage	50c per mile

"Injuries covered by flat fees, the last schedule published by the State Industrial Accident Commission, less one-third."

Ex. 2710; R. 6997-8:

"Regarding operations, we believe you are familiar with the Association's regulations, which are that the attending doctor must obtain authority in advance of performing an operation, reporting his findings and giving as complete information as possible with reference to the patient's employer, length of time under our protection, etc."

Ex. 2717; R. 7011:

" . . . we have investigated the matter of these shots for the treatment of the condition, and the advice we have from medical men here is that while the shots are many times effective as a prevention of hay fever the proper time to use them is before the hay fever season . . . Under the circumstances the Association would not feel justified in paying for this service."

Ex. 2718; R. 7011 et seq. (Schedule of fees, rules and regulations of National Hospital Association, August 30, 1940):

R. 7015:

"GENERAL SURGERY"

" . . . *Authority and Consultation required for major surgery*. (See Rules and Regulations.)"

. . . . . .

R. 7016:

"EYE, EAR, NOSE AND THROAT"

" . . . Authority and Consultation for major surgery required."

. . . . . .

R. 7016:

"UROLOGY"

" . . . Authority and Consultation Required for Major Surgery."

. . . . . .

R. 7016:

"FRACTURES"

"*Authority and Consultation Required for Open Reductions and other Major Work*"

. . . . . .

R. 7017:

"X-RAYS—INCLUDING WRITTEN DIAGNOSIS"

*Authorization required—See Rule 2, Rules and Regulations, page 8."

. . . . . .

R. 7019:

"RULES AND REGULATIONS"

"1. *Charges for surgical operations will be assumed by the* National Hospital Association *only where complete diagnosis, including proper laboratory tests, has been provided and written Authority to operate at the Association's expense has first been obtained. In Emergencies* doctors should proceed to operate, and the Association will accept the charges as provided herein if the employe is found eligible."

. . . . . .

R. 7020:

"3. . . . but the Association will not assume charges for x-rays for medical diagnosis unless work is done by a qualified roentgenologist and authority for such examination is first obtained.

. . . . . .

"4. Charges for *Physical Therapy,* including Diathermy, Electrotheraphy, etc. and charges for other special services will be assumed by the Association only after authority to provide such services at the Association's expense has first been obtained."

APPENDIX C

Extracts from testimony of doctors on practices of commercial hospital associations and the doctors' reasons for opposing them.

"I did not study medicine for the purpose of having some third party broker my services without my knowledge and without my consent" (R. 1441).

"You can't measure the practice of medicine entirely in terms of dollars and cents" (R. 1022).

"It no longer became a matter of the doctor thinking what is best for that patient. You, first of all, had to obtain permission to do what you thought was best for the patient" (R. 1074).

"I believe that any contract 300 miles away from its source should not have to call up a layman in Portland to get permission to do an acute appendix" (R. 1020).

"I did not like distant supervision and looking down the back of my neck to see whether I did things the way they liked them or not. I felt . . . that they were in no position to judge whether I was treating a case properly or improperly; and when they objected and told me I could treat a case the way they wished, I just simply told them I was through" (R. 1227).

"They told me when I could take GI studies; they told me when I could take x-rays; they told me when I could do surgery" (R. 1229).

"They took contracts to furnish medical aid to industrial groups in our area and then would allow the local physicians to do first aid work and that is about all" (R. 1576).

"The thing that impressed itself to the greatest degree upon my mind was not that the interference was worse when I as a physician had trouble with some hospital association . . . but the interference was at its worst when I as a physician and the hospital associations were getting along beautifully" (R. 1284).

"They questioned your procedure to the point where it was insulting, when it came to almost ques-

tioning your ethics, and I just got fed up with it" (R. 1602).

"Every time I would send them a bill, say, for instance, for four calls or five calls, they would cut about one call off and then send a long cock-and-bull story about they didn't allow so many treatments for that kind of a case, until I got sick and tired of it" (R. 1595).

"I found myself working for the National Hospital Association and not for my patients which I did not like and I could not tolerate it longer. I had to get permission to do anything that I did" (R. 1733).

APPENDIX D

Chronological list of events in various Oregon counties, other than Multnomah, 1936-41, showing lack of uniformity or concert of action.

1936

Nothing sems to have happened outside of Multnomah County during this year.

1937

Clackamas County

It was during this year, it seems, that the doctors of this county formed the Clackamas County Physicians Association, described as a "partnership" of these doctors (R. 1098-9). In the course of time many of the doctors in this county, but by no means all, refused to work for hospital associations or to accept their tickets.

Jackson County

November. A resolution to "sever all connections" with commercial hospital associations was proposed (Ex. 1255; R. 4783). It was referred to at subsequent meetings but was not passed (Ex. 956-7; R. 4336-8).

Lane County

December. Many doctors of Eugene, in a concerted action, wrote letters that they would no longer work directly for hospital associations (E.g., Ex. 1400-3; R. 4996-9).

1938

Jackson County

January 8-10. Industrial Hospital Association is asked by an employer at the request of employees to add Dr. Dodson to its panel at Medford, but refuses. In October it again refuses (Ex. 2684; R. 6948-50).

December. Several doctors from this county notified National and Industrial Hospital Associations that they would not take care of their members except as private patients (E.g., Ex. 1348-63; R. 4945-53).

Lane County

December 8. Industrial Hospital Association writes that it is having no trouble taking care of its accounts in Eugene notwithstanding the "boycott" (Ex. 535; R. 3597).

1939

January 5. Industrial Hospital Association writes employer that "all activities in regard to any boycott in this state so far as we know, have ceased . . . " (Ex. 530; R. 3590-3).

Clatsop County

May 12. Clatsop Society decided that they would take care of all cases for National Hospital Association and Industrial Hospital Association, but not for Multnomah Industrial Health Association, the doctors' organization (Ex. 911, 913; R. 4293, 4295).

August 28. (Ex. 912; R. 4295) Clatsop County modifies its former resolution so that now it takes cases from all hospital associations. The reason for this change was that Multnomah Industrial Health Association agreed to Clatsop County's fee schedule demand (R. 1064).

Wasco County

November. (Ex. 1233, 2000; R. 4756, 6102-3). Mid-Columbia Medical Society invites all commercial hospital associations to do business in their county, on condition that they do not make individual full-coverage contracts in the upper income brackets.

Klamath County

December. (Ex. 1152; R. 4666, 4668). Klamath Medical Service Bureau provides that all doctors may work for commercial hospital associations provided such associations list all doctors in Klamath Falls on the panel.

1940

Coos County

January. Seven doctors, owners of four small private hospitals, notify hospital associations they will not accept their tickets (Ex. 20, 568; R. 2130, 3613).

Lake County

January 16. (Ex. 1108; R. 4619-20). Four doctors of Lakeview Hospital, Inc., notify National that because of National's attitude in disclaiming responsibility, they will not handle National cases.

Umatilla County

February 11, 19. (Ex. 2037; R. 6323). Umatilla County Society, through its President, defendant Brennan, writes to State Society to ascertain whether State Society has approved the National Hospital Association.

Jackson County

October 9. (Ex. 2701; R. 6976-7). The "boycott" started December, 1938, is terminated and each physician may do as he pleases.

Lane County

December. (Ex. 1020; R. 4398). Lane County Society takes cognizance of the fact that Industrial and National have many doctors in county taking care of their members.

1941

Jackson County

March 14. Industrial Hospital Association says "most of the doctors in Medford are being very fair in their treatment of us" (Ex. 2723; R. 7025).

September. (Ex. 1854, 2702; R. 6733, 6986-7). Jackson County Medical society insists that all its members be placed on panel of Industrial Hospital Association. Letter sent to California-Oregon Power Company listing the doctors who should be on the panel.

By 1941 Jackson County doctors also active in working for National Hospital Association. (See Ex. 2204 to 2214; R. 6621 to 6715).

Washington County

December. Several doctors from Washington County write letters to employers that they no longer will work for National Hospital Association (Ex. 26-31; R. 2135-8).

December 6, 1941, Articles of Incorporation of OPS filed.

During the period 1935-1940, inc., the gross income of commercial hospital associations increased as follows: Industrial Hospital Association, $217,114.00 to $404,970.00; National Hospital Association, $490,558.00 to $567,901.00; Prudential Hospital Association, $33,584.00 to $83,218.00 (R. 4810, 4829).

APPENDIX E

Extracts from trial Judge's charge to jury in *United States v. American Medical Association,* et al., 110 Fed. (2d) 703 (1st Appeal), 130 Fed. (2d) 223, Aff'd. 317 U.S. 519.

> "The defendants had the right to reach and attempt to reach their objective of advancing the interests of the medical profession by legitimate persuasion and reasoned argument, and to this end they had the right to tell their side of the story and to persuade others including the Washington Hospitals, other physicians, members of Group Health

Association, Inc., and the public to utilize and use the defendants' method of practicing medicine, and to use peaceful persuasion, publicity, articles in the press, in publications of defendants, including THE JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION, and all lawful propaganda to have their methods of practicing medicine prevail over those of Group Health Association.

"The defendants had the right to write letters or other statements among themselves or to other members of the profession or to the public generally, expressing disapproval of or opposition to Group Health Association and the form of medical service offered by it.

"The defendants were entitled, through legitimate persuasion and reasoned argument, to endeavor to support and advance the interests and extension of that type of medical practice believed by the defendants to be in the public interest, without regard to whether such acts hindered Group Health Association, its doctors, members or operations, or any other type of method of medical practice. If they did not go further to conspire to restrain Group Health Association there would be no offense."

. . . . . .

"If the defendants had objections to Group Health Association and the type of medical practice proposed by it, and believed that the system of medical practice approved by the defendants was better and more in the public interest, then the defendants were lawfully entitled, either individually or collectively, through legitimate persuasion and reasoned argument, either publicly or privately, to urge any and all persons to come to the support of the objectives of the defendants and to disapprove the objectives of Group Health Association, its doctors, members or operations is not in violation of the law." (R. 1500-1503, *American Medical* case.)

APPENDIX F

Contentions made by Anti-Trust Division in United States v. American Medical Association, et al.

(1) The vice of commercialization of medical practice.

> "Commercialization of the practice of medicine occurs when a corporation seeks to make a pecuniary profit from the services of doctors employed by it. The profit motives under such an arrangement tends to subordinate the interests of the patient to the financial success of the corporation which may lead to intervention by the corporation in the medical affairs of the doctors in order to further the profit object of the corporation." (Brief filed on behalf of the United States in Court of Appeals for the District of Columbia, January 26, 1942, in *American Medical Association v. United States*, p. 82.)

(2) Inapplicability of American Medical Association decision to cases under sec. 1 of Sherman Act.

> "Petitioners also urge (Pet. 20) that the question decided by the Court of Appeals is one of substance relating to the construction of a statute of the United States. But the court has construed only section 3 of the Sherman Act and only in so far as that section relates to activities wholly within the District of Columbia. See *Ex parte Bakelite Corp.*, 279 U.S. 438, 450. The decision below is therefore the equivalent of the construction of a statute limited in its operation to the District of Columbia, which this Court will not ordinarily review. *Del Vacchio v. Bowers*, 296 U.S. 280, 285.
>
> "It is unlikely that the holding of the Court of Appeals that restraints upon the practice of medicine fall within the meaning of the words 'restraint

of trade' in section 3 will influence the enforcement of the Sherman Act beyond the District of Columbia. Section 1, which also prohibits combinations 'in restraint of trade,' is limited in its application to restraints affecting *interstate* trade and commerce. Since the practice of medicine is usually an *intrastate* activity, it is not likely that secton 1 could be invoked against restraints upon the practice of medicine in the states." (Brief for United States in opposition to petition for writ of certiorari, July, 1942, pp. 20-1.)